

Adult Registration Form

SECTION 1: PERSONAL INFORMATION- ALL AREA'S MUST BE COMPLETED

Current Date (MM/DD/YYYY):	
Do you reside in the Town of Georgina?	□ Yes □ No
Legal Name	Preferred first name
Date of Birth (MM/DD/YYYY):	
Sex:	☐ Male ☐ Female Gender Identification: (Optional)
Home Address:	CITY POSTAL CODE
Phone:	Home: () - Cell: () -
Emergency Contact:	Name: Phone No:
Health Card Number:	Expiry date (MM/DD/YYYY):
Who is completing this form?	☐ Self ☐ Other - Name: Phone No: Relationship: ☐ Spouse ☐ Child ☐ Friend ☐ Other (specify):
Who has been your previous provider? Eg; Nurse Practitioner/Doctor?	Name: Address: Phone number: () Fax Number: ()
Pharmacy:	Name:

SECTION 2: MEDICATIONS & ALLERGIES

List all medications that you use: (include all prescriptions, over the counter	products, and supplements). If
more than 5 please attach pharmacy list.	

ie: Tylenol		vnat Strength? ie: 500mg	How n	nany? How often?
Fo you have any drug allergies? Fives, please list name of drug ar				
yes, prease not name or arag ar	Indicate Reaction			
Name of Drug	Rash	Shortness of Breath	Nausea	Other (Specify)
SECTION 3: PAST MEDIC	CAL HISTO	DRY		
Which medical conditions do yo	u have now	or have you had i	in the past?	(Please check all that apply)
Eye & Ear			 	
☐ Macular degeneration	☐ Cata	racts		☐ Glaucoma
☐ Hearing loss/hearing aid(s)	☐ Other (specify):			

SECTION 3: PAST MEDICAL HISTORY – Continued

Heart		
☐ Heart attack, year:	☐ Heart failure	☐ High blood pressure
☐ Aortic stenosis	☐ Heart valve problem	☐ Angina
☐ High cholesterol	☐ Pacemaker	☐ Atrial fibrillation
☐ Irregular heartbeats (arrhythmias)	☐ Other (specify):	
Gastrointestinal Tract		
☐ Heartburn/reflux/GERD	□ Ulcers	☐ Irritable bowel
☐ Liver disease/cirrhosis	☐ Hepatitis	☐ Gallbladder disease
☐ Colon polyps	☐ Bleeding problems	☐ Diverticulosis
☐ Constipation	☐ Hemorrhoids	☐ Celiac
□ Other (specify):		
Bones & Joints		
☐ Gout	☐ Lower back pain	☐ Osteoporosis
☐ Rheumatoid Arthritis	☐ Arthritis	☐ Fractured bones
Location of above:		
Glands		
☐ Thyroid	☐ Thyroid overactive (high)	☐ Thyroid underactive (low)
□ Diabetes	☐ Other (specify):	

SECTION 3: PAST MEDICAL HISTORY – Continued

Kidney & Urinary Tract			
☐ Frequent bladder infections	☐ Kidney disease ☐ Enlarged Prostate		
☐ Urinary incontinence	☐ Kidney stones		
☐ Other (specify):	,		
Lungs			
☐ Asthma	☐ Bronchitis	☐ COPD/emphysema	
☐ Recurrent pneumonias	☐ Other (specify):		
Nervous System			
☐ Dementia or Alzheimer's disease	☐ Parkinson's disease	☐ Epilepsy or seizures	
☐ Neuropathy/nerve damage	☐ Stroke		
☐ Other (specify):			
Mental Health			
☐ Anxiety	☐ Depression		
☐ Other (specify):			
Cancers			
☐ Breast	☐ Prostate	☐ Colon/Rectum	
Lung	☐ Lymphatic	Skin	
☐ Other (specify):	,	,	

SECTION 3: PAST MEDICAL HISTORY – Continued

Other Health Buchlane		
Other Health Problems	T	
☐ Hernia	☐ Anemia	☐ Thrombosis / blood clots
☐ Syncope (loss of consciousness)	☐ Sexual function problems (specify):	
☐ Other (specify):		
SECTION 4: SCREENING TE	STS	
TEST	DATE MOST RECENTLY DONE	RESULTS (IF RELEVANT)
Eye examination		
Hearing Test		
Bone Mineral Density (BMD)		
Colonoscopy		
Colon Cancer Check (FOBT or FIT)		
Fasting Bloodwork		
MEN ONLY		
TEST	DATE MOST RECENTLY DONE	RESULTS (IF RELEVANT)
Prostate Exam (rectal exam)		
PSA blood test (prostate cancer screening)		
If you have ever smoked then an abdominal ultrasound to check for aortic aneurysm		
WOMEN ONLY		
TEST	DATE MOST RECENTLY DONE	RESULTS (IF RELEVANT)
PAP test (cervical cancer)		
Mammogram		

SECTION 5: VACCINATIONS

Dates of your last vaccinations. (If you have record please bring with you)

Flu vaccine	Year:	Reaction: Yes / No
Pneumonia vaccine	Year:	Reaction: Yes / No
Tetanus booster	Year:	Reaction: Yes / No
Zostavax (Shingles)	Year:	Reaction: Yes / No

SECTION 6: SOCIAL HISTORY

Are you presently:	☐ Single/Never married	☐ Married
	☐ Divorced/Separated	☐ Widowed
With whom do you live (please	□ Alone	☐ Spouse or Partner
check all that apply):	□ Child	
	☐ Other family member (specify): _	
	☐ Others, not family (specify):	
If living at a facility, please list the names of person and the contact number for medical treatment order:		
How many children do you have?		
Are you in regular contact with your children?	□ No □ Yes	
How much school did you	☐ Less than 8 th grade	☐ Some high school
complete?	☐ High school graduate	☐ Some college/university
	☐ College/University graduate	☐ Graduate school
Are you presently working?	☐ Working full time	☐ Working part time
	□ Not working	☐ Retired
List your principal occupation and any other significant occupations:		

SECTION 7: LIFESTYLE

Do you drink alcohol, including beer and wine or hard liquor (i.e. vodka, whiskey, gin)?	□ Daily			
	☐ A few times a week (specify number of days:			
	☐ Less than once a week			
	□ Never			
How much do you drink at a time? (One drink = 12oz of beer or 8-9oz	□ 1 drink □ 2 drinks			
of malt liquor or 5oz of table wine	☐ 3 drinks ☐ 4 drinks			
or 1.5oz of hard liquor)	☐ 5 or more drinks ☐ None			
Have you EVER smoked?	☐ Cigarettes ☐ Cigars			
	☐ Chew tobacco			
Do you currently smoke cigarettes?	□ No □ Yes			
	If no, when did you quit? Year:			
	For how many years did you smoke?			
	How many packs per day? □¼ □½ □1 □1½ □2+			
	If yes , how many packs per day? $\square \%$ $\square \%$ $\square 1$ $\square 1\%$ $\square 2+$			
	Would you like to quit? ☐ No ☐ Yes			
Do you vape?	☐ No ☐ Yes; please specify amount, quantity and frequency			
Do you use cannabis?	☐ No ☐ Yes; please specify amount, quantity and frequency			
Do you use street drugs?	☐ No ☐ Yes; please specify amount, quantity and frequency			

SECTION 8:

PLEASE LIST SPECIFIC HEALTH CONCERNS THAT YOU WOULD LIKE YOUR NURSE PRACTITIONER TO KNOW ABOUT BEFORE YOUR VISIT:

Please be sure to include any information not already reported in this form.

1.

2.

3.