In order to provide adequate medical care, I require the following information. It may be of significance in the evaluation of your problem or should you require medication or surgery. If you do not understand any of the questions, please put a "?" beside it. Thank you for your cooperation.

A. NAME: _____ **Age:** _____

WHAT IS THE PURPOSE OF THIS VISIT? TO DISCUSS: _____

B. PAST MEDICAL HISTORY

(a) MEDICAL Have you had or do you have any problems with:

	Yes	No		Yes	No
Heart Attack			Cirrhosis		
High Blood Pressure			Ulcers		
Angina			Diabetes		
Rheumatic Fever			Kidney Disease		
Other Heart Problems			Glaucoma		
Asthma / Bronchitis			Cancer		
T.B.			Bleeding Problems		
Other Lung Problems			Other _____		
Hepatitis / Jaundice					

(b) ANY OPERATIONS Any complications or problems:

(c) HAVE YOU HAD:

	Yes	No	Comments
General Anesthetic			_____
Local Anesthetic (Freezing)			_____

(d) ALLERGIES:

_____

(e) MEDICATIONS PRESENTLY BEING TAKEN:

_____

_____

Any Steroids / Cortisone / Prednisone in the last 6 months? Yes ☐ No ☐

(f) TETANUS IMMUNIZATION in last 10 years? Yes ☐ No ☐

(g) FAMILY HISTORY Has anyone in your family had problems with:

	Yes	No
Bleeding Disorders		
Diabetes		
T.B.		
Cancer		
Kidney Disease		
Problems with Anesthetics		
Other _____		

(h) PERSONAL HISTORY

Occupation: _____

Smoker: Yes ☐ No ☐ If yes, how much? (be honest) _____

Have you smoked in the past year? Yes ☐ No ☐

Average daily alcohol intake: _____

Are you RIGHT HANDED ☐ or LEFT HANDED ☐

Would you object to a blood transfusion if it was advised by your doctor? Yes ☐ No ☐

(i) Do you have any of the following conditions now?

	Yes	No
Pregnancy		
Shortness of Breath on Exertion		
Palpitations		
Swollen Ankles		
Anemia / Low Blood		
Loose / Capped Teeth		
Skin Rashes		
Infection		
Other _____		

THIS SECTION TO BE COMPLETED BY THE DOCTOR

C. GENERAL EXAMINATION

To the best of my knowledge, this information is accurate at this time.

Patient's Signature: _____ **Date:** _____

REGISTRATION FORM

Please Print

Date: _____

Mr. / Mrs. / Miss / Ms. _____

(full name of patient as it appears on his / her Care Card)

Birth Date: Day: _____ Month: _____ Year: _____ Age: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Daytime Phone: _____

Next of Kin: Name: _____ Phone: _____

Care Card No.: _____

Family Doctor: _____ Referring Doctor*: _____

* *IF SEEN IN AN EMERGENCY DEPARTMENT - GIVE HOSPITAL AND EMERGENCY ROOM PHYSICIAN*

WCB Claim No.: _____ Employer: _____

ICBC Claim No.: _____ Adjustor: _____

Date of Injury / Accident: _____