

## NEW PATIENT REGISTRATION FORM

Please complete this form prior to your first appointment for review by your physician. This form is designed to streamline your appointment and to ensure that important issues are not overlooked.

### Personal Information

Patient Name: \_\_\_\_\_

Relationship Status: \_\_\_\_\_

Children: \_\_\_\_\_

Current Occupation: \_\_\_\_\_

Previous Family Doctor's Contact Information:

\_\_\_\_\_

### Medical History

Current/Ongoing Medical Conditions (e.g. high blood pressure, high cholesterol, irritable bowel syndrome, depression, etc.):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Previous/Resolved Medical Conditions (e.g. childhood asthma, eczema, broken wrist, etc.):

\_\_\_\_\_  
\_\_\_\_\_

Surgeries/Procedures or Hospitalizations (please include the year and details of any time you had surgery, or were admitted to the hospital overnight):

\_\_\_\_\_  
\_\_\_\_\_

Prescription Medications (include name of medication, dose/strength, and how often you take it, e.g. Lipitor 10mg once per day):

\_\_\_\_\_  
\_\_\_\_\_

Over the Counter and Herbal Products:

\_\_\_\_\_



Allergies (include the trigger and the reaction you get, e.g. penicillin - rash, peanuts - hives):

Smoking History:  Current Smoker - Number of cigarettes per day \_\_\_\_\_  Previous smoker  Never smoked

Alcohol History: Number of drinks/week: \_\_\_\_\_

Name and Contact Information of Specialists Involved in Your Care:

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### Family Medical History

Heart disease, heart attack:  NO  YES

Family Member and Age at Diagnosis: \_\_\_\_\_

Stroke:  NO  YES

Family Member and Age at Diagnosis: \_\_\_\_\_

Diabetes:  NO  YES

Family Member and Age at Diagnosis: \_\_\_\_\_

Thyroid disorder:  NO  YES

Family Member and Age at Diagnosis: \_\_\_\_\_

Breast, ovarian, colon or prostate cancer:  NO  YES

Family Member and Age at Diagnosis: \_\_\_\_\_

Mental Illness (e.g. anxiety, depression, bipolar, schizophrenia):  NO  YES

Family Member and Age at Diagnosis: \_\_\_\_\_

Other Relevant Family Medical History:

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Please bring all your **medications** and **immunization records** to your first appointment.

