

### PATIENT INFORMATION

**ADULT**    
 **CHILD**    
 **ADULT UNDER GUARDIANSHIP**    
 **NAME OF GUARDIAN**

Name \_\_\_\_\_ Mrs.  Ms.  Mr.   
(First) (Last)

Home Address \_\_\_\_\_  
(Street) (City) (Province) (Postal Code)

Home Phone \_\_\_\_\_ Cellular Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex\* \_\_\_\_\_ Marital Status \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Medical Specialist (If Presently Under Care) \_\_\_\_\_ Phone \_\_\_\_\_

### OCCUPATION

Employed By \_\_\_\_\_ Phone \_\_\_\_\_ Ext. \_\_\_\_\_

Spouse Employed By \_\_\_\_\_ Phone \_\_\_\_\_ Ext. \_\_\_\_\_

### PERSON RESPONSIBLE FOR ACCOUNT

Self  Other  Name \_\_\_\_\_

Address \_\_\_\_\_

Business Phone \_\_\_\_\_ Ext. \_\_\_\_\_

### IN CASE OF EMERGENCY

Please Notify \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Ext. \_\_\_\_\_

Is any other member of your family or relative a patient at our office? \_\_\_\_\_

### REASON FOR TODAY'S VISIT

Examination  Emergency  Other  \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

### MEDICAL HISTORY

<b>Please check YES or NO, If not sure check NS.</b>	NO	NS	YES	
Are you presently under Doctor's Care?*				
When was your last complete physical examination?*				
Are you currently in good health?*				
Do you smoke?* How many a day? For how long?				
Do you use recreational drugs? *				
Are you presently taking any medication, pills or drugs?*				→ If YES, list them here.
Have you had any type of surgery?*				→
Have you been hospitalized in the past two years?*				
Have you ever taken cortisone/steriod medication?*				

**Medications:**