

ONTARIO HEALTH CLINICS BRANTFORD FHO

Patient Pre-Registration

PLEASE FILL OUT ALL SECTIONS.

Detailed answers will help us to best take care of you.

<hr style="border: 0.5px solid black;"/> <p style="text-align: center;">Name</p> <p style="text-align: center;"><i>(office use: apply label)</i></p>
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Lifestyle

Age	Single	Occupation	Hobbies
M / F	Married / Common law		
	Divorced / Separated		

Allergies

Drug	Other
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Smoking

Yes: # per day -

No Quit: year -

Alcohol

Yes: # per week -

No

Name and location of your last Family Doctor:

Dr.	Date of last physical:
Why did you leave?	

Current pharmacy: _____

Current medications including dosage:

1.
2.
3.
4.
5.
6.
7.

Pain medications, herbal supplements, and vitamins, including dosage:

1.
2.
3.
4.
5.
6.
7.

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Current Medical History and age or year diagnosed (eg. Heart Attack 2016)

1.
2.
3.
4.
5.
6.
7.
8.

Admissions to hospital in the past 12 months: the date, where, and why

1.
2.
3.

Past surgical procedures, including the date and the name/location of specialist

1.
2.
3.
4.

Specialists who currently follow you, including why and when you next see them

1.
2.
3.

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Must complete all sections

Family History, including chronic illnesses, diseases, and at what age they were diagnosed.

Mother			
Father			
Sister			
Brother			
Grandmother			
Grandfather			

Past tests: indicate the last year performed or n/a if not completed.

	Year		Year
Mammogram		PSA	
Bone Mineral Density		MRI (<i>indicate body part</i>)	
Pap Smear		ECG	
Colonoscopy		Cardiac Stress test	
FOBT (blood in stool)		Vision Check	

Immunizations: indicate the last year received or n/a if not completed.

	Year		Year
Tetanus		Herpes Zoster	
Hepatitis A / B		Influenza	
Pneumonia		Other -	
HPV (Gardasil)		Other -	

Other personal or health information you would like us to know (*optional*):

Your expectations of care as we move forward in helping with your health care needs (*optional*):