# **HEALTH REGISTRATION FORM - domestic**

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| PATIENT INFORMATION  |  |  |  |  | | --- | --- | --- | --- | | Title: (circle one)  Miss Ms. Mrs. Mr. N/A | Last Name: | First Name: | Preferred Name: |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Address: | | | | | | | | | | City: | | | Postal Code: | | | (residence is M2J 5G3) | | | | Phone numbers where you can be reached: | Home | | ( ) | | | | Voicemail: Yes No | | | Cell | | ( ) | | | | Voicemail: Yes No | | | Work | | ( ) | | | | Voicemail: Yes No | | | May we leave a detailed message on any of these numbers? Yes No  **\*\*no personal information will be left \*\*** Please specify: 🞏 Home 🞏 Cell 🞏 Work | | | | | | | | | | Personal Email: | | | Seneca Email: | | | | | | | Date of Birth: **Y Y Y Y / M M / D D** | | | Gender (circle one): | Male | | Female | | Prefer not to say | | Health Card #: # # # # **/** # # # **/** # # # | | | Version: **\_\_ \_\_** (Ontario only)  Or, specify which province:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | Seneca ID #: # # # **/**  # # # **/** # # # | | | | Family Physician: | | | | | Phone #: | | | | | Address: | | | | | | | | | | City: | | Postal Code: | | | Fax #: | | | |  IN CASE OF EMERGENCY  |  |  |  | | --- | --- | --- | | Name of local friend or relative: | | Relationship: | | Address: | | | | City: | Postal Code: | Phone #: | |
| Health Information Do you have any allergies? Yes No (circle one)  If yes, do you use an epi-pen? Yes No (circle one) Please list allergies:   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | **Present or Past Illness(es)** | **Yes** | **No** | **Comments** |  | |  | Diabetes |  |  |  |  | |  | Epilepsy |  |  |  |  | |  | Asthma |  |  |  |  | |  | Heart Disease |  |  |  |  | |  | High Blood Pressure |  |  |  |  | |  | Headaches |  |  |  |  | |  | Any previous diagnosis or medical conditions (ex. cancer, syndromes) |  |  |  |  | |  | History of: Muscle / Bone injuries |  |  |  |  | |  | Mental Health Issues (incl. anxiety, depression) |  |  |  |  | |  | Infectious Disease (e.g. Hepatitis C) |  |  |  |  | |  | Weight Loss or Gain (unexplained) |  |  |  |  | |  | Hospitalizations (in the past year) |  |  |  |  | |  | **Presently Describe:** | | | |  | |  | Birth Control Use |  |  |  |  | |  | Alcohol/Drug Use  (if yes, please indicate amount/frequency) |  |  |  |  | |  | Sleeping well? |  |  |  |  | |  | Do you smoke?  (if yes, please incl. how often, since when) |  |  |  |  | |  | Do you take any medication? (Please list each drug by name including drugs for birth control, smoking cessation, epilepsy, blood pressure, etc.): | | | |  | |
| The information submitted on this form is true to the best of my knowledge. I understand the information contained herein is **confidential**. It is intended for use by the Seneca Medical Centre staff only in the event that I require their services. I further understand that this information will **NOT** be released to anyone outside the Medical Centre without my written permission.   |  |  |  |  |  | | --- | --- | --- | --- | --- | |  |  |  |  |  | |  | Patient’s signature |  | Date |  | |  | Freedom of Information and Protection Privacy Act 1987. The information on this form is collected under the legal authority of the College and Universities Act, R.S.O. 1980. C272, SS; Regulated Health professions Act 1991, S. 36(1) for the use of the Health Centre Staff. | | |  | |