# **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 InformationDo 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.

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| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  | 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. |  |

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