MAPLE MEADOWS HEALTH CENTRE

Patient Registration Form

Patient Information
Last Name: _____ First Name: _____
Date of Birth: _____ Personal Health Care No: _____ Sex:○ Female ○ Male
Address: _____ City: _____
Postal Code: _____ Contact Phone:_____ Alternate Phone: _____
Email: _____
Emergency Contact: _____ Emergency Contact Phone: _____

For Pediatric Patients	
Parent Name:	Parent Name:
Address: City: Postal Code: Contact Phone:	Address: City: Postal Code: Contact Phone:

Medical Problems	**Date of Diagnosis**

Any Previous Surgery or Procedures	**Date of Procedure**

Medication List		
Name	**Strength**	**Directions of Use**

MAPLE MEADOWS HEALTH CENTRE

Patient Registration Form

Medical Allergies

Over-the-Counter Medications taken regularly

Do you chew Tobacco: Y / N If Yes, how often: _____

Do you smoke cigarettes: Y / N If Yes, how many times per day: _____

Do you drink Alcohol: Y / N If Yes, how often do you drink: _____

Substance use History: Y / N If Yes, please explain: _____

FOR FEMALE PATIENTS
Last Pap Smear for females aged between 25 and 70
Last Mammogram History for females aged 40-75:

Vaccination History

Name	**Date**	**Name**	**Date**

For Patients aged 50 and Over
Have you participated in fecal testing for bowel cancer: Y / N **If so, when was the last sample date:**
Any other information we should know:

Email back to: ***info@maplemeadowshealth.ca*** ***Phone: 604-380-4351***