

LISGAR WOODS MEDICAL CENTRE

REGISTRATION FORM

PERSONAL HISTORY

LAST NAME: _____

FIRST NAME: _____

HEALTH CARD# _____ VERSION CODE: _____

DATE OF BIRTH: (YY-MM-DD) _____ SEX: MALE FEMALE

ADDRESS: _____

CITY: _____ POSTAL CODE: _____

HOME TEL: _____ OTHER TEL: _____

EMAIL: _____

EMERGENCY CONTACT

NAME: _____

TELEPHONE NUMBER: _____ RELATIONSHIP: _____

MEDICAL HISTORY

	YES	NO
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>
ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>
HIGH CHOLESTEROL	<input type="checkbox"/>	<input type="checkbox"/>
SMOKE	<input type="checkbox"/>	<input type="checkbox"/>

OTHER MEDICAL ISSUES LIST: _____

CURRENT MEDICATIONS: _____

ALLERGIES: _____

LAST TETANUS: _____ (YEARS)