DIXIE ROAD MEDICAL ASSOCIATES

NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE

SURNAME:	FIRST NAME:
ADDRESS:	APT/UNIT:
	POSTAL CODE:

PHONE #:

HOME:	WORK:	CELL:
EMAIL ADDRESS:		

DATE OF BIRTH:	MALE: FEMALE:

HEALTH CARD #:	VERSION CODE:

HAVE YOU BEEN TOLD YOU HAVE ANY OF THE FOLLOWING?:

Heart disease: Yes No	**Arthritis:** Yes No	**Diabetes:** Yes No
Lung disease Yes No	**Thyroid problems**: Yes No	
High blood pressure: Yes No		
Drug allergies: Yes No		
Other allergies: Yes No		
Other problems (Please describe): Yes No		

PLEASE LIST ALL DRUGS YOU ARE CURRENTLY TAKING:

DRUG NAME:	DOSE:

IMMUNIZATIONS:

TYPE:	DATE:

PLEASE LIST ALL PREVIOUS ILLNESSES AND SURGERY:

CONTACT IN CASE OF EMERGENCY:

NAME:	PHONE #:
RELATIONSHIP:	

Date:

PATIENT'S SIGNATURE: