Patient Information

Name: _____
(Last name, First Name Middle Initial.)

Gender: Male ____ Female ____ Other: _____

Date of Birth (YYYY/MM/DD): (_ _ _ _ /_ _ /_ _)

Height (in cm 2.54 cm = 1 inch): _____

Weight (in kg 1kg = 2.2 pounds): _____

Address: _____ Apt/Suite: _____

City: _____ Province / Territory: (_ _)

Postal Code: _____

Phone (Home): _____ Phone (Work): _____

Health Card Number: _____

Check the immunizations you have had:

- ☐ Hepatitis A
  Date: _____
- ☐ Hepatitis B
  Date: _____
- ☐ Influenza (flu)
  Date: _____
- ☐ Measles
  Date: _____
- ☐ Rubella
  Date: _____
- ☐ Tetanus
  Date: _____
- ☐ Varicella (Chicken Pox)
  Date: _____

Allergies:

1) _____
2) _____
3) _____

Surgeries (Operations): Please list any surgeries you have had:

1) _____ Date: _____
2) _____ Date: _____
3) _____ Date: _____

Check the diseases or conditions you or a family member has had.

Disease/Condition	You	Family	Relationship
Diabetes	☐	☐	
Cancer: Type: _____	☐	☐	
Asthma	☐	☐	
High Blood Pressure	☐	☐	
High Cholesterol	☐	☐	
Heart Disease	☐	☐	
Depression	☐	☐	
Arthritis	☐	☐	
Other: _____	☐	☐	

Emergency Contact: _____

Relationship: _____ Phone: _____