# IDA REXDALE 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 | ❐ | ❐ |
| HEART DISEASE | ❐ | ❐ |
| DIABETES | ❐ | ❐ |
| ASTHMA | ❐ | ❐ |
| HIGH CHOLESTEROL | ❐ | ❐ |
| SMOKE | ❐ | ❐ |

OTHER MEDICAL ISSUES LIST: ___________________________________________________________

______________________________________________________________________________________

CURRENT MEDICATIONS:__________________________________________________________________

______________________________________________________________________________________

ALLERGIES: ___________________________________________________________________________

LAST TETANUS: ____________ (YEARS)