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NEW PATIENT REGISTRATION FORM

Date: _____

PATIENT INFORMATION

NAME: _____ GENDER: _____

DATE OF BIRTH: (MM/DD/YYYY): _____ MARITAL STATUS: _____

ADDRESS: _____

HOME PHONE: _____ MOBILE: _____ WORK: _____

EMAIL ADDRESS: _____

HEALTH CARD #: _____ VC: _____ EXP: _____

PARTNER/SPOUSE NAME: _____

CHILDREN (if applicable) NAME & AGE: _____

PREVIOUS FAMILY PHYSICIAN: _____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: _____ PHONE: _____

MEDICAL HISTORY

ALLERGIES: (medications, food, seasonal/environmental, latex, other):

ALLERGIC TO: _____ REACTION: _____

CURRENT MEDICATIONS: (including prescriptions, vitamins, and herbal supplements)

CURRENT HEALTH CONCERNS: (e.g., high blood pressure, pain, low mood, diabetes etc.)

PAST SURGERIES OR HOSPITALIZATIONS: (please include year and reason for hospitalization)

1. _____
2. _____
3. _____
4. _____

LAST MAMMOGRAM (MM/DD/YYYY) _____

LAST PAP SMEAR (MM/DD/YYYY) _____

LAST FIT/SCOPE (MM/DD/YYYY) _____

FAMILY HISTORY (record relationship: mother, father, sister/brother, grandparents, children)

☐ HEART ATTACK _____	☐ STROKE _____
☐ DIABETES _____	☐ HIGH BP _____
☐ DEMENTIA _____	☐ SEIZURES _____
☐ HIGH CHOLESTEROL _____	
☐ CANCER (specify type) _____	

OTHER: _____

SOCIAL HISTORY

OCCUPATION _____

DO YOU SMOKE? ☐ YES ☐ QUIT (YEAR) _____ ☐ NO IF YES ☐ CIGARETTES/CIGAR ☐ CANNABIS

HOW MANY CIGARETTES/PACKS A DAY? _____

HOW MANY YEARS? _____ # QUIT ATTEMPTS _____

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO IF YES, # OF DRINKS PER WEEK _____

HAVE YOU EVER USED RECREATIONAL DRUGS? ☐ YES ☐ NO IF YES, WHICH DRUGS _____

CURRENT MEDICAL SPECIALISTS (please include name, type of specialist and date of last visit)

****PLEASE MAKE SURE TO ARRIVE TO YOUR APPOINTMENT 15 MINUTES EARLY****

Thank you,
Wilson Medical Group