DR. CHRIS TAYLOR'S
PATIENT REGISTRATION FORM

PATIENT'S NAME: ____
{FULL NAME WITH SURNAME FIRST AND ALL GIVEN NAMES}

CARE CARD NUMBER: ______________________________

PROBLEM TO BE DISCUSSED: ____

DATE OF INJURY/ONSET: ____________________________ DATE OF SURGERY: ____________________

DATE OF BIRTH: ______/______________/________ AGE: ____________ MALE _____FEMALE:_______
DAY MONTH YEAR

ADDRESS: ____________________________ CITY: ____________ PROV: _______ POSTAL CODE: _________

PHONE: HOME ________________ BUSINESS ________________ CELL ______________ FAX __________

CONTACT PERSON AND PHONE: ____

FAMILY DOCTOR: __________________________________ REFERRING DOCTOR: ____________________

ALLERGIES: ____ LATEX ALLERGIES: YES or NO

MEDICATION{S} YOU ARE CURRENTLY TAKING:
____

DO YOU TAKE ANY OF THE FOLLOWING OVER THE COUNTER MEDICATIONS?
Ginko Biloba __________ Ginseng ____________ Vitamin E ____________ Aspirin ____________

HAVE YOU HAD: GENERAL ANAESTHETIC {PUT TO SLEEP} YES NO LOCAL FREEZING YES NO

LIST OPERATIONS: ____
____
____

COMPLICATIONS: ____

PAST MEDICAL HISTORY: {Please circle any of the problems you have had}

HEART ATTACK	H.I.V.	ASTHMA	GLAUCOMA
HIGH BLOOD PRESSURE	HEPATITIS{type______}	BRONCHITIS	CANCER
ANGINA	CIRRHOSIS	DIABETES	ARTHRITIS
RHEUMATIC FEVER	ULCERS	KIDNEY DISEASE	BLEEDING PROBLEMS
PACEMAKER/DEFIBRILLATOR			

ANY OTHER: ____

TETANUS IMMUNIZATION IN THE LAST 10 YEARS? YES NO

ANY STEROIDS/CORTISONE/PREDNISONE/ACCUTANE IN THE LAST SIX MONTHS? YES NO

IF YOU SMOKE, HOW MANY PER DAY? ______________ ALCOHOL INTAKE DAILY/WEEKLY ________

DOMINANT HAND: RIGHT LEFT AMBIDEXTROUS

OCCUPATION: ______________________________ INTERESTS/HOBBIES ______________________

ONLY FILL IN IF APPLICABLE:
Workers' Compensation Claim #: ________________ Date of Injury: ______________ Employer: ______________
Military {DND}: Service # ____________________
R.C.M.P. Employee: YES
I.C.B.C. #: ________________ Date of Injury: _________