Last Name: **First Name:**

DOB: **OHIP:** **My Age:**

Address:

Phone Number: **Cell Phone:** **Email:**

Current Health Problems (and approx. date of onset):

-
-
-
-
-
-

Medications (names, doses, frequency of use):

-
-
-
-
-
-

Past Medical History (resolved problems, surgeries, hospital):

-
-
-
-
-
-

Family Medical Problems:

- Mother
- Father
- Siblings
- Grandparents
- Children

Allergies:

-
-
-
-
-

Specialists I See:

-
-
-
-
-
-

Other Issues:

-
-
-
-

Risk Factors:

[ ] I Smoke
[ ] I Drink Alcohol

[ ] My Exercise Regimen
[ ] My Job

My last Tetanus Shot was ___________
My last Flu shot was _______________

This form is confidential when completed.

Please use back of form if required.