Pearl Family Practice
11 - 1107 Lorne Park Road, Mississauga ON,
L5H 3A1
Tel: 905 271 5717 Fax: 866 217 9886

New Patient Registration Form

Dr Ekta Golani

PATIENT INFORMATION

Last Name:		Given Names:	
Date of Birth: dd / mm / yyyy	Age:	Health Card:	VC:
Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Separated ❒ Widowed ❒ Other: _____		Sex: ❒ Male ❒ Female ❒ Other: _____	
Street Address:			
City:		Postal Code:	
Home Phone:		Cell Phone:	
Email Address:			
Preferred Pharmacy:			

WORK INFORMATION

Employer:	
Occupation:	Work Phone:

EMERGENCY CONTACT

Contact Person: (First Name, Last Name)	Relationship to Patient:
Contact Phone #1:	Contact Phone #2:

PERSONAL MEDICAL HISTORY

Medical History

- ❒ **High Cholesterol**
- ❒ **High Blood Pressure**
- ❒ **Diabetes**
- ❒ **Heart Attack / Heart Disease / Heart Failure**
- ❒ **Asthma or Chronic Lung Disease**
- ❒ **Epilepsy**
- ❒ **Osteoporosis**
- ❒ **Arthritis, Gout, or Joint Injuries**
- ❒ **Depression, Anxiety or Mental Health Issues**
- ❒ **Thyroid Disease**
- ❒ **Other:** _____

Cancer

❒ **Breast** ❒ **Colon/Bowel** ❒ **Prostate**
❒ **Lung** ❒ **Other**

Surgical or Procedure History

	YEAR
☐ **TONSILS/ADENOIDS**	
☐ **APPENDIX REMOVAL**	
☐ **GALLBLADDER SURGERY**	
☐ **JOINT REPLACEMENT**	
☐ **COLONOSCOPY**	
☐ **UPPER ENDOSCOPY**	
☐ **THYROID SURGERY**	
☐ **PROSTATE SURGERY**	
☐ **C/SECTION**	
☐ **OTHER**	

For Women Only

# of pregnancies:	# miscarriages/abortions:	# of children:
Date of Last Pap smear:	Date of Last Mammogram:	

PLEASE TURN OVER

MEDICATIONS			
Please list all medications, including non-prescription drugs and herbals.			
Medication	Strength/Dose	# Tablets/Dose	How often
Immunization History:	Dates:		Dates:
☐ Flu Shot		☐ Tetanus	
☐ Pneumovax		☐ Shingles	

ALLERGIES	
Please list all drug, food, and environmental allergies.	
Allergy	Type of Reaction (e.g., rash, breathing problems, etc.)

HABITS
Smoking Status: ❒ Never Smoked
❒ Currently Smoke: How many packs per day? _____ For how many years? _____
❒ Quit Smoking: When did you quit? _____ For how long did you smoke? _____
Alcohol Consumption: How many drinks per week? _____
Recreational drug use:

FAMILY HISTORY					
Medical Condition	Relative(s) with condition	Age when diagnosed	Medical Condition	Relative(s) with	Age when diagnosed
High Blood Pressure			Colon/Bowel Cancer		
Heart Disease			Breast Cancer		
Stroke			Arthritis		
Diabetes			Depression		
High Cholesterol			Bipolar Disorder		
Asthma			Schizophrenia		
Thyroid					
Other Cancers (provide details):					
Other Conditions (provide details):					