VyCare Medical Clinic

3587 Kingsway, Vancouver BC, V5R 5L9 *604-913-5666*

New Patient Registration

Please complete this form prior to your first appointment for review by physician

PATIENT INFORMATION			
Last Name:	First:	Middle:	Sex: ☐ M ☐ F ☐ X
Is this your legal name?	Language Spoken:	☐ English	DOB: Day / Month / Year
☐ Yes ☐ No	☐ Other (*Please specify*):		/ /
Personal Health no.:			
Street address	City	Postal Code	
Email Address:			
Home phone: ( )	Cell phone: ( )	Work phone: ( )	
Occupation:	Employer:		

Why Vycare: ☐ Doctor referred ☐ Family ☐ Friend ☐ Close to Home/Work ☐

Other family members seen here:

Marital status: Partner Name: Sex:

Number of Pregnancy: *number of Children:*

Emergency Contact		
Name of local friend or relative (not living at same address):	Relationship to patient:	Phone number:
		( )

Pharmacy name and address:

Pharmacy Phone:

Pharmacy Fax:

*Patient Initials:*_____

MEDICAL HISTORY

Current/Ongoing Medical Conditions (eg: Diabetes, HTN, Depression, Anxiety, ADHD, Heart condition)	1. _____ 2._____ 3._____ 4. _____ 5. _____
Screening Tests	Year / Month / Date Colonoscopy: ☐ Never ☐ Yes / / Mammogram: ☐ Never ☐ Yes / / PAP: ☐ Never ☐ Yes / /
Past Surgeries / Hospitalizations	Surgeries ☐ Never ☐ Yes Reason: _____ Date: ____/_____/_____ Surgeries ☐ Never ☐ Yes Reason: _____ Date: ____/_____/_____ Surgeries ☐ Never ☐ Yes Reason: _____ Date: ____/_____/_____ Hospitalizations: ☐ Never ☐ Yes Reason: _____ Date: ____/_____/_____ Hospitalizations: ☐ Never ☐ Yes Reason: _____ Date: _____/_____/_____ Hospitalizations: ☐ Never ☐ Yes Reason: _____ Date: _____/_____/_____

First child name: Medical condition:

Second child name: Medical condition:

Third child name: Medical condition:

Fourth child name: Medical condition:

Patient Initials:_____

List of Medications	Name 1,_____ 2,_____ 3,_____ 4,_____	Dose 1,_____ 2,_____ 3,_____ 4,_____
List of Allergies	Allergen 1,_____ 2,_____ 3,_____ 4,_____	Reaction 1,_____ 2,_____ 3,_____ 4,_____
Smoking/ Alcohol History	Smoking: ☐ Never ☐ Yes. How many a day_____ Alcohol: ☐ Never ☐ Yes. How many a day_____	

FAMILY MEDICAL HISTORY

Heart Disease/Heart Attack	☐ No ☐	Yes, Family member:_____ Age at diagnosis:_____
Stroke	☐ No ☐	Yes, Family member:_____ Age at diagnosis:_____
High Blood Pressure	☐ No ☐	Yes, Family member:_____ Age at diagnosis:_____
Diabetes	☐ No ☐	Yes, Family member:_____ Age at diagnosis:_____
Thyroid Disorder	☐ No ☐	Yes, Family member:_____ Age at diagnosis:_____
Cancer: (Please circle) Breast/Ovarian/Colon/Prostate Other: _____	☐ No ☐	Yes, Family member:_____ Age at diagnosis:_____
Mental Illness: (Please circle) Anxiety/Depression/Bipolar/ Schizophrenia/Other: _____	☐ No ☐	Yes, Family member:_____ Age at diagnosis:_____
Other: (Anything you'd like to add)		

Patient Initials:_____