Vital Transitions Clinic

Helping you embrace the changes in your life

9901 Keele Street, unit 109, Maple, Ontario, L6A 3Y5
Tel: 905-951-3428 Fax: 905-951-9716
Email: admin@vitaltransitions.ca

NEW PATIENT REGISTRATION FORM

PLEASE PRINT

DATE: _____

SURNAME:_____ FIRST NAME: _____

DATE OF BIRTH (dd/mm/yyyy): _____

ADDRESS:

_____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

HOME TEL: _____ BUS. TEL: _____

MOBILE: _____ EMAIL: _____

OHIP NO: _____ VERSION CODE: _____

SEX: MALE __ FEMALE __

MARITAL STATUS: _____ CHILDREN :____

OCCUPATION: _____

HOW DID YOU HEAR ABOUT THIS CLINIC?

_____

NAME OF CONTACT IN CASE OF EMERGENCY (AND TEL. NUMBER):

_____

SMOKER ? NO ___ YES ___

ALCOHOL CONSUMPTION: _____

LIST OF MEDICATIONS (DOSAGES/FREQUENCY/FOR WHAT REASON):

_____

_____

_____

_____

_____

_____

DRUG ALLERGIES:

_____

_____

FAMILY HEALTH HISTORY (Note cause of death if deceased):

MOTHER:_____

FATHER:_____

SISTERS:_____

OTHER FEMALE RELATIVES:_____

OTHER RELEVANT FAMILY HISTORY:_____

PAST MEDICAL CONDITIONS:_____

_____

_____

PAST SURGERIES:_____

_____

PLEASE LIST YOUR MAIN CONCERNS THAT BROUGHT YOU TO THE CLINIC:

_____

_____

_____

_____

PLEASE CIRCLE BELOW IF YOU ARE CURRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS:

GENERAL:

Fatigue	**Hot flashes**	**Fainting**
Loss of Appetite	**Night sweats**	**Fever**
Weight loss	**Heat intolerance**	**Chills**
Weight gain	**Cold intolerance**	**Easy bruising**
Difficulty sleeping	**Bloating**	**Decreased sex drive**

SKIN:

Dry skin	**Facial hair**	**Acne**
Hair loss	**Rashes/hives**	

HEART AND CIRCULATION:

Palpitations	**Leg pain while walking**	**Swelling of the ankles**
Chest pain /tightness	**Varicose veins**	

DIGESTION:

Difficulty swallowing	**Abdominal pain**	**Gas**
Heartburn	**Constipation**	**Regular laxative use**
Nausea/ Vomiting	**Loose bowel movements**	**Bloody/ Black stools**

URINATION:

Frequent urination	**Change in appearance of urine**	**Bladder infections**
Painful urination	**Problems holding urine**	
Getting up at night to urinate……	**If so, how many times _____**	

SKELETAL SYSTEM:

Pain or stiffness of joints	**History of fractures**	**Back pain**
Swelling of joints	**Foot problems**	**Deformities**

NERVOUS SYSTEM:

Forgetfulness	**Abnormal sensations**	**Spells of any kind**
Nervousness/Anxiety	**Loss of balance**	**Dizziness**
Depression	**Difficulty walking**	**Muscle weakness**
Foggy thinking	**Clumsiness**	**Tremors**

MENSTRUAL/GYNECOLOGICAL HISTORY:

Regular cycles	**Painful Breasts/Lumpy breasts**
Irregular cycles	**Infertility**
Painful menstruation	**Abnormal vaginal discharge**
Very heavy periods	**Vaginal dryness**
Bleeding between periods	**Painful intercourse**
Length of periods _____ Days	**Length of cycle _____Days**
Age of 1st period ____	**Number of pregnancies ____**

Number of Miscarriages ____

Are you using any method of contraception?

What method are you using/used in the past? _____

Date of last period_____ Date of last pap smear_____

Date of last mammogram/breast ultrasound _____

Name of Family Doctor _____ Date of last physical _____