

# THE TORONTO CENTRE FOR SPORTS MEDICINE

## PATIENT REGISTRATION

*Please complete this form and return to front desk with your health card*

Health Card #: \_\_\_\_\_ Version Code: \_\_\_\_\_  
(Alphabetic Code)

Name: \_\_\_\_\_  
Last name First name

Address: \_\_\_\_\_ Apt/Unit#: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone #: H: ( ) \_\_\_\_\_ B: ( ) \_\_\_\_\_ Ext. \_\_\_\_\_

Date of Birth: \_\_\_\_\_  
Day Month Year

Do you have extended health coverage i.e. dental, prescriptions?  N  Y

If you have answered yes, please provide name of insurance company \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Referred by:  Sign  Friend  Billboard  Internet  Yellow Pages  Doctor \_\_\_\_\_

Other (please specify) \_\_\_\_\_

*Office Use Only:*

Chart #	
Letters	

**Please Complete Reverse** è

**Medical Profile** (please check appropriate boxes)

Diabetes	<input type="radio"/> Y <input type="radio"/> N	Abdominal/Intestinal Problems	<input type="radio"/> Y <input type="radio"/> N
Pacemaker	<input type="radio"/> Y <input type="radio"/> N	Hepatitis	<input type="radio"/> Y <input type="radio"/> N
Migraine	<input type="radio"/> Y <input type="radio"/> N	High Blood Pressure	<input type="radio"/> Y <input type="radio"/> N
Cancer (any type)	<input type="radio"/> Y <input type="radio"/> N	Ulcers	<input type="radio"/> Y <input type="radio"/> N
Kidney Disease	<input type="radio"/> Y <input type="radio"/> N	Bleeding Tendencies	<input type="radio"/> Y <input type="radio"/> N
Heart Disease	<input type="radio"/> Y <input type="radio"/> N	Epilepsy	<input type="radio"/> Y <input type="radio"/> N
Thyroid Problems	<input type="radio"/> Y <input type="radio"/> N	HIV	<input type="radio"/> Y <input type="radio"/> N
Asthma/Lung Problems	<input type="radio"/> Y <input type="radio"/> N	Psychiatric Illness	<input type="radio"/> Y <input type="radio"/> N

If you have answered yes to any of the above, please provide details: \_\_\_\_\_

Do you have a medical condition for which you see a doctor or take medication regularly? Specify \_\_\_\_\_  Y  N

Have you had any surgery in the past? Specify \_\_\_\_\_  Y  N

Are you or could you be pregnant?  Y  N

Do you have any allergies to medications? Specify \_\_\_\_\_  Y  N

Do you take any medications on a regular basis? I.e. vitamins, birth control. Specify \_\_\_\_\_  Y  N

Do you smoke? What do you smoke? \_\_\_\_\_ Amount per day \_\_\_\_\_ Years \_\_\_\_\_  Y  N

Do you drink alcohol? Type \_\_\_\_\_ Amount \_\_\_\_\_ Frequency \_\_\_\_\_  Y  N

**Social History**

Marital Status: Single  Married  Separated  Divorced  Widowed  Common-Law

Children(# and ages) \_\_\_\_\_

Occupation: \_\_\_\_\_

Physical activities outside of work: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_