ASTRO MEDICAL CLINIC

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NEW PATIENT FORM

- DATE: _____ PHONE#: _____
- FIRST NAME: _____ MB REG#: _____
- LAST NAME: _____ PHIN#: _____
- D.O.B: (MM/DD/YYYY): _____
- ADDRESS: _____
- POSTAL CODE: _____
- DO YOU PRESENTLY HAVE A FAMILY DOCTOR? YES/NO

  IF YES, WHO IS YOUR FAMILY DOCTOR: _____
- LIST ALLERGIES IF APPLICABLE: _____

  _____
- DO YOU USE NARCOTICS REGULARLY? (Ex. MORPHINE, PERCOCET, T3) YES/NO
- LIST OF MEDICATIONS: _____

_____

- Please **circle** one: SMOKER / NON-SMOKER / Ex-SMOKER

Please give a brief Medical History (PLEASE CHECK ALL THAT APPLY)

__Anxiety
__Arthritis
__Asthma
__Cancer
__Chronic Fatigue Syndrome
__Depression
__Diabetes
__Fibromyalgia
__Heart Disease
__Hepatitis
__High Blood Pressure
__High Cholesterol

Others: _____

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