Lakehead
Nurse Practitioner-Led Clinic

Suite 101- 325 S. Archibald St.
Thunder Bay, ON, P7E 1GB Tel:
807-475-9595
Fax: 807-475-9797

Client Registration Form
Forms may be submitted by fax, mail or in person

Surname:_____ Given Names:_____

Health Card #_____ Version Code_____ Expiry:_____

Date of Birth_____

Phone Number: (home)_____ (work)_____ (cell)_____

Address:_____

_____ Postal Code_____

Gender_____ Language(s):_____

Emergency Contact/Next of Kin:_____ Relationship:_____

Phone Number: (home)_____ (work)_____ (cell)_____

Address:_____

Please complete for all clients with a legal guardian, and for all children less than 16 years of age if different than above:

Primary Guardian:_____ Relationship:_____

Phone Number: (home)_____ (work)_____ (cell)_____

Address:_____

In general, how would you describe your health: ___excellent ___ very good ___good ___fair ___poor

Are you currently under the care of any other primary care provider? ___YES ___NO

_____

_____

_____

_____

Where did you hear about the Lakehead Nurse Practitioner-Led Clinic?_____

By signing below, you agree that there have been no omissions or misrepresentations regarding your health history or current treatments. Failure to properly disclose your health status may result in an inability for the Lakehead NP-Led Clinic to meet your health care needs.

Signature:

_____ Date:_____

Well baby	
EMS -CP	

Medical History

Allergies	Cardiac	Surgery / Procedures
☐ None	☐ None	☐ None
Medical Allergies:	☐ Angina	Surgery / Procedure — Date
Food Allergies:	☐ Arrhythmia	
	☐ Atrial Fibrillation	
	☐ Cardiomyopathy	
	☐ Congestive Heart Failure	
	☐ Congenital	
	☐ Heart Attack	
	☐ High Blood Pressure	
	☐ Pacemaker	
	Other	

Current Medications

Medication	Prescription or Non-Prescription (over the counter)	Reason for Taking	Dosage Per Day

Pharmacy: _____

Medical Problems

☐ None	☐ High Cholesterol	☐ Substance Abuse specify
☐ Arthritis specify	☐ HIV +	☐ Thyroid
☐ Asthma	☐ Hypertension	☐ Trouble Hearing
☐ Blood Disorder specify	☐ Kidney Disease / Dialysis specify	☐ Tuberculosis
☐ Cancer specify	☐ Liver Disease	☐ Visually impaired
☐ COPD / Emphysema	☐ Mental Health specify	
	☐ Pain	

☐ Diabetes Type I, Type 2, Prediabetes _____	specify _____	Other_____
☐ Gastrointestinal specify _____	☐ Paralysis specify _____	
☐ Gynecological specify _____	☐ Seizures specify _____	
☐ Headaches	☐ Skin Condition specify _____	
☐ Hepatitis specify _____	☐ Stroke Date _____	

Specialists Seen

NAME	DATE	REASON FOR VISIT

Lifestyle

Smoking:

Yes No

Total years smoked_____

cigs/day_____

Previous, # of years_____

Year quit_____

Alcohol:

Yes No

# of drinks /week_____

Recreational Drug Use:

Yes No

List_____

Marital Status:

Single
Married / Common Law
Widow / Widower
Children #_____

Education (last year of school completed)

_____

Currrently a student: Yes No

Place of Employment

_____

Type of Employment

_____

Retired Yes No Year _____

Family History

Do you have a family history of disease, i.e. parents or siblings with: heart disease, stroke, high blood pressure, diabetes, cancer, high cholesterol, etc.

Please list relationship and disease

FAMILY MEMBER	DISEASE	AGE OF ONSET	ALIVE or DECEASED

Results

Date of your last:

Physical Check Up _____

Blood Work _____

Pap test _____ ☐Normal ☐Abnormal

Bone Density _____ ☐Normal ☐Abnormal

Mammogram _____ ☐Normal ☐Abnormal

Colon Cancer Screening _____ ☐Normal ☐Abnormal

Prostate Exam _____ ☐Normal ☐Abnormal

Immunization Record

Up to date: ☐**Yes** ☐**No** ☐**Don't know**

Date of Last Tetanus: _____ **Date of Last Flu Vaccine:** _____

Date of Pneumonia Vaccine: _____