For Dr. Osayi

The Core Family Health Centre
825 Richmond Street
London, ON N6A 3H7
Tel : 519-963-1875 Fax: 519-963-1880
www.corefamilyhealth.com

Patient Registration

Full Name: _____ Gender: M/F/other
Birth date: _____
Street Address: _____ London, ON
Postal Code: _____
Home Phone #: _____ Cell Phone #: _____
Work Phone #: _____
Previous Family Doctor: _____ Last Pap/Physical: _____

Medical Information

Current Health Goals/Medical Issues:

_____ _____

_____ _____

_____ _____

Current Medications:

_____ _____

_____ _____

_____ _____

_____ _____

If your children are under 18, you may register them with you on this form.

Child's Name: _____ Birth date: _____ Gender: M/F

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I understand that submission of this form does not guarantee admission to Dr. Osayi's practice and that the information I have provided is accurate.

Signature: _____

Name (print): _____ Date: _____

The Core Family Health Centre

Dr. Izuagbe Osayi MBBS, CCFP

825 Richmond St.
London, ON N6A 3H7
T. 519.963.1875 F. 519.963.1880

Thank you for considering joining our practice.

My first obligation as a medical doctor is to provide quality care to all of my patients. In order to do this, you and I must cooperatively and respectfully work together towards your health and well-being.

Please complete the following medical history form to the best of your ability or knowledge. If you are uncertain of a date, the approximate year would be helpful. If it does not apply to you, please cross it out or write "N/A".

Full Name & Date of Birth: _____

Address: _____

Phone Number: _____ Email: _____

Health Card #/Version Code: _____

Next of Kin (Name, relationship to you, address and contact details):

_____

_____

Past Medical History (Diagnosis and year of diagnosis):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Previous Family doctor and why did you leave?

_____

_____

Allergies: _____

_____

Preferred Pharmacy (Phone number/address if known):_____

_____

Medication List (Name, dose, frequency & duration):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Over the counter medications/vitamins: _____

_____

Last complete physical (month and year): _____

Last blood work (month and year): _____

Last Pap test (Females every 3 years from 21 to 70): _____

Mammogram (Females 50-69 years of age): _____

FOBT Colon Cancer Screening (every 2 years 50-74 years of age):_____

Colonoscopy: _____

Bone Mineral Density Test for osteoporosis (over 65 or any age with risk factors:

_____

Immunization/Vaccination History (please list or attach a copy of your vaccination records:

_____

_____

_____

Examples of Vaccination Recommendations for the Province of Ontario:

Tetanus –every 10 years / Flu Shot / Hepatitis B / Shingles / HPV

Pneumovax: Diabetes, COPD & some other chronic medical conditions which may entail low immunity.

Family History (medical diagnosis in your family –their relationship to you and age at time of diagnosis):

_____

_____

_____

Home Circumstance (who lives at home with you; family/friend support):

_____

_____

Occupation (if retired, job before retirement): _____

_____

Smoking status (if ex-smoker, when you stopped, how many daily and for how long?):

_____

Alcohol use (how many drinks per week): _____

Diet (any special diets, fruits/vegetables, etc.): _____

_____

Do you drive? (please circle): Yes No

Please use the space below if you feel there is any additional information we should know in order to provide you with the best care possible.