PAGDIN HEALTH
LIVING LONGER BETTER
Dr. Grant Pagdin, MD
WWW.PAGDINHEALTH.COM

Registration Form – Procedures

Name: ____ **Date:** ____________________

Health Card Number: _____________________________ **Male** | **Female** (please circle)

Birth date (DD-MM-YYYY): _____________________

Address, City, Postal Code: ____

____

Please check your primary contact number

☐ Home Phone: ___________________________ ☐ Cell Phone:___________________________

☐ Work Phone:___________________________

Family Physician:___________________________

Do you want your family physician to be kept informed of your progress? Yes or No **(circle your reply)**

Occupation: ____

Email Address: ____

May we add your email to our Health Living Newsletter list? Yes or No **(circle your reply)**

May we communicate with you via email correspondence? Yes or No **(circle your reply)**

Emergency Contact Name: __________________________________

Number: _________________________________

How did you hear about us? ____

Lifestyle

Do you smoke? ☐ No, never have ☐ No, quit at the age of _________, started at age _________

☐ Yes, how often? ___________________________ How long have you smoked? ________

How often do you drink alcohol? ______________________________ Alcohol type(s): _______________________

How often do you exercise? ________________________________ Type(s) of exercise: ___________________

Do you abide by a special diet? ☐ No ☐ Yes If yes, what type? (Vegan, Celiac, etc.)

____

Allergies: ____

Medications: ____

____

Supplements: ____

____

Past Medical History:

- ☐ Heart Disease/Heart Attack
- ☐ High Cholesterol
- ☐ High/Low Blood Pressure
- ☐ Diabetes
- ☐ Thyroid Disease (Grave's/Hashimoto's/Hypo/Hyper/Unknown)
- ☐ Deep Vein Blood Clots
- ☐ Stomach Ulcers
- ☐ Cancer: ____
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Stroke
- ☐ Asthma/COPD
- ☐ Irritable Bowel Syndrome
- ☐ Crohn's or Ulcerative Colitis
- ☐ Celiac Disease
- ☐ Other: ____

Surgical History

List any past surgeries:	Date of surgery:
____________________________________	_________________________________
____________________________________	_________________________________
____________________________________	_________________________________
____________________________________	_________________________________
____________________________________	_________________________________

We require 48hrs notice for any appointment change/cancellation or a No-Show Fee may be applied ($200). Payment will be required prior to scheduling additional appointments.

I agree to the above policies. Signature: ____