REGISTRY FORM

Last, first name: _____

☐ Female ☐ Male

Date of birth: (D/M/Y) _____ /_____ /_____

Phone number: _____

E-mail: _____

Allergies: _____

Medication used regularly:

- ☐ Inhaler/puffer
- ☐ Blood pressure medication
- ☐ Diabetes medication
- ☐ Cholesterol medication
- ☐ Pain medication
- ☐ Depression medication
- ☐ Ulcer/reflux medication
- ☐ Other:_____

Height: _____ (feet/inches or meters) Weight: _____ (pounds or kg)

Smoking history (please check applicable box):

- ☐ I have always been a non-smoker
- ☐ I used to smoke _____cigarettes/day for _____ years, but I have stopped ____ years ago
- ☐ I am currently smoking _____ cigarettes/day

Date of today: (D/M/Y) _____ /_____ /_____

Version 6, October 31st, 2013