Hospital Registration

Please fill out the details to register yourself with our hospital!

* Required

1. Registration date *

2. Full name *

3. Date of birth *

4. Address *

5. Phone number *

6. E-mail address *

7. Employment Status *

- ◯ Full-time
- ◯ Part-time
- ◯ Contract
- ◯ Temporary
- ◯ Seasonal
- ◯ Self-employed
- ◯ Unemployed

8. Employer *

9. Are you currently taking any medications? *

- ◯ Yes
- ◯ No

10. List all medications. *

11. Emergency contact information *

12. Special notes

13. Height(in cm) *

14. Weight(in kg) *

15. Do you drink alcohol? *

- ◯ Yes
- ◯ No

16. Do you smoke cigarettes? *

- ◯ Yes
- ◯ No

17. Do you use any recreational drugs? *

- ◯ Yes
- ◯ No

18. Do you have any pre-existing medical conditions? *

- ◯ Yes
- ◯ No

19. Please specify what kind of medical condition you have. *

20. Is there a history of serious illness is in your family? *

- ◯ Yes
- ◯ No

21. If yes, please specify.

22. Date of last blood pressure check *

23. Results of last blood pressure check *

24. What is your COVID-19 vaccination status? *

- ◯ One dose only
- ◯ Two doses
- ◯ Three doses
- ◯ Unvaccinated
- ◯ Other