NEW PATIENT REGISTRATION DATE: ……..

FAMILY NAME…….. Miss/Mrs/Mr/Dr/Other: ……

FORENAMES: ……..

DATE OF BIRTH: ……. ……

HOME ADDRESS: ……
……..
…… Postcode……..

CONTACT DETAILS: Telephone: ……(Home) Mobile: ……

Email address……..

OCCUPATION: ……

ALLERGIES TO ANY MEDICATIONS: ……..
……..

Name of Medical Insurer: (If Applicable) ……..
……

METHOD OF PAYMENT: Cash / Cheque / Debit Card / Credit Card / Accounts not settled at time of appointment will incur the current administration fee.

CURRENT HEALTH

How would you describe your present health? GOOD / FAIR / POOR (Please circle)

Is your weight: STABLE / INCREASING / DECREASING

How many cigarettes/cigars/ounces of tobacco do you smoke per week? ……

If you stopped smoking please state, the year you stopped: ……

How much alcohol do you drink - on average per day? ……..

On average per week? …….

Are you taking any medication on a regular basis? Please state name(s) and dose(s) (This includes the oral contraceptive pill). ……
……
……
……
……

Please give details of the type and frequency of any exercise you take:
……
……
…….

FEMALE PATIENTS ONLY

Have you ever had an abnormal smear test result, Seen a doctor about lumps in the breast or had advice/ NO YES

Treatment for abnormal periods? Have you had any abnormal pregnancies or labours? NO YES

Please state the date of your last smear test and Smear test date: ……

Mammogram if you have had one. Mammogram test date: ……

TRAVEL/VACCINATION HISTORY

Have you travelled to countries other than in Europe or North America in the last 3 years? Details of which countries in what year NO YES
……
……

Will you be expected to travel as part of your current/new job? Details of which countries and how often NO YES ……
……

Have you had any vaccinations? Tetanus, Typhoid, Polio, Hepatitis A, any others? Date(s) of last vaccination or booster. NO YES ……
……

ETHNICITY GROUP In line with our registration with the Healthcare Commission, we are required to obtain information about our Patient's ethnicity. We would be grateful if you would place a tick in the appropriate box below. This information is not used for any purpose other than statistical data for the Healthcare Commission.

Your Ethnic Group Tick Here :

White : British

White : Irish

White Other :

White Mixed :

White and Black Caribbean Mixed :

White and Black African Mixed :

White and Asian Mixed :

Other mixed Asian or Asian British :

Indian Asian or Asian British :

Pakistani Asian or Asian British :

Bangladeshi Asian or Asian British :

Other Asian Black or Black British :

Black Caribbean Black or Black British :

Black African Black or Black British :

Other Black Chinese or Other Ethnic Group :

Chinese Chinese or Other Ethnic Group :

Other Ethnic Group Arabic Other :

MEDICAL HISTORY Please complete the following as fully as possible indicating the year of occurrence, the treatment given and the outcome.

Have you ever seen a doctor for any of the following conditions:

(Please circle)			**Please give details / Year**
Chest pains, abnormal blood pressure, palpitations, shortness of breath, rheumatic fever, swollen ankles or any other heart condition?	NO	YES	
Asthma, bronchitis, pneumonia, persistent cough, coughing up blood or any other chest condition?			
Rheumatism, painful joints, arthritis, gout, back pain, slipped disc or sciatica?			
Stomach pains, constipation, severe vomiting, severe diarrhoea, stomach ulcers, colitis, diverticulitis, piles, rupture or disease of the liver or gall bladder?			
YES Sugar, protein or blood in the urine, cystitis, bladder or ureter or renal colic, passage of stone or gravel in urine, prostate problems or difficulty in passing water?			
Diabetes, thyroid problems, abnormal hormone levels?			
Cancer, tumour or malignancy? NO YES Hepatitis, yellow jaundice, malaria or other infectious diseases contracted abroad?			
Epilepsy, migraine, stroke or other neurological diseases? NO YES Have you ever experienced significant bouts of anxiety, low moods or suffer from a mental health illness?			
Have you ever had an operation?			
Have you any other past medical problems such as accidents, fractures or out patient investigations not already mentioned?			
Significant eye or ear disease?			

FAMILY HISTORY AGE STATE OF HEALTH/CAUSE OF DEATH

Father ……..

Mother …….

Brothers ……

Sisters ……

Spouse …….

Children …….

Grandparents ……

Have any of the above ever suffered from tuberculosis/diabetes/epilepsy/heart disease/high blood pressure or glaucoma? Circle where appropriate NO YES

NEXT OF KIN: (Relationship)…….
…… ……

Telephone No(s)……

ON REQUEST WE WILL PROVIDE YOU WITH COPIES OF YOUR TEST RESULTS. DO YOU WANT US TO PROVIDE DETAILS OF YOUR MEDICAL REPORTS TO YOUR NHS GP? (OR ANY OTHER DOCTOR?)
YES/NO Full Name & Address of Doctor(s) to be notified: ……
.……
……

It is our Practice Policy to provide a chaperone for all female pelvic and breast examinations. Chaperones are also available for any other intimate examinations, no matter what your gender is. If you would like a chaperone, please inform us.

It is our Practice Policy that all paediatric examinations must be carried out in the presence of a parent or guardian.

Please note we request that CDs and hard copies of X-rays and scans are held by the patient.

The Practice understands that the information given in this document is provided in the STRICTEST CONFIDENCE and assure you that it is protected under the Data Protection Act and within the security of your personal file.

In keeping with GDPR legislation, we are committed to respecting both your trust and privacy. We will store your details securely and treat them responsibly. We will also never pass your data to third parties without your knowledge. Your details may be used from time to time for general communication between The Practice and patient.

Should you prefer not to be contacted in this way, please tick here.

I have read, understood and answered the questions to the best of my knowledge.

Signed: ……

Dated: …….

(For office use only) ID Provided ……. Signed ……..