

NEW PATIENT REGISTRATION CONSULTATION

DATE: _____ TIME: _____

PERSONAL DETAILS

Name _____ Date of Birth _____ Marital Status _____

Address _____

_____ Post Code _____ Tel.No _____

No of Children _____ Occupation _____ *Place of Birth _____

*Ethnicity _____ Is a Carer _____ Has a Carer(At home/External Carer)

Carer Tel no _____ Carer Support _____

MEDICAL HISTORY

Have you had any serious illnesses, operations or accidents? YES/NO Details _____

Are you on any prescribed drugs or medicines? If so, what are they ? _____

Are you allergic to any drugs or medicines? YES/NO Details _____

Ladies only: When did you last have a cervical smear? _____

Are you on the contraceptive pill? YES/NO If so, which one? _____

LIFESTYLE

How much do you smoke per day? _____ How much alcohol do you drink per week? _____

Do you take regular weekly exercise? YES/NO If yes, is this light, moderate, heavy?(please circle)

FAMILY HISTORY

Does anyone in your family(Mother, Father, Sister, Brother) suffer from:

Heart disease over 60/below 60 : specify who _____

Stroke YES/NO specify who _____

Diabetes YES/NO specify who _____

Asthma YES/NO specify who _____

Any other significant _____

HEALTH SCREEN

Blood Pressure _____

Weight _____

Height _____

B.M.I _____

Urinalysis _____

ACTION

Update Immunisation DO/DONE

Update smear DO/DONE

Make contraceptive claim DO/DONE

GP Signature _____ Date _____