New Patient Registration Form

Townhead

PLEASE COMPLETE ALL SECTIONS AND SIGN (*Mandatory Fields)

PERSONAL DETAILS			
FIRST NAME:	*	TITLE	
MIDDLE NAME:		DOB:	
SURNAME:	*	NATIONALITY:	
ADDRESS:		OCCUPATION:	
		POST CODE:	*
NEXT OF KIN	*	RELATIONSHIP:	
ADDRESS:			
		POST CODE:	
PHONE NO:		MOBILE NO:	

CARER	
Are you a carer?	YES/NO
If Yes, who do you care for?	
Are you cared for?	YES/NO
If Yes, who cares for you and relationship?	

MEDICAL HISTORY - **Have you ever suffered from any of the following, if so tick (√) box and give approximate date:**

Diabetes			Asthma & Other Lung Diseases		
High Blood Pressure			Heart Disease/Angina		
Stroke/Mini Stroke			Thyroid Problems		
Epilepsy			Alcohol or Drug Problems		
Mental Health			Other		

CURRENT MEDICATION: ITEMISE ALL MEDICATION OR ATTACH PREVIOUS GP'S REORDER FORM

Name of Medication	Form (Capsule/Tablet)	Frequency	Strength

CURRENT OVER THE COUNTER MEDICATION:			
Name of Medication	**Form (Capsule/Tablet)**	**Frequency**	**Strength**

DO YOU HAVE ANY ALLERGIES? **YES/NO**
Please list:

FAMILY HISTORY	
Is there any family history of diabetes	YES/NO
If YES, please provide details and age of onset	
Is there any family history of heart problems?	YES/NO
If YES, please provide details and age of onset	
Is there any family history of stroke?	YES/NO
If YES, please provide details and age of onset	
Please provide the following information, of any other illness in the family that may be relevant:	

FEMALES				
When was your last cervical smear taken?				
What was the result of your last smear?				
Are you using contraception at present?				
Contraception Used – Please circle and indicate any renewal dates.				
Oral Contraception Pill	Coil	Implant in Arm	Condoms	Injection