

NEW PATIENT APPLICATION FORM

Please complete in BLOCK CAPITALS and as appropriate

Patient Details

Mr Mrs Miss Ms Surname _____

Date of Birth _____ First Name(s) _____

Address _____

Telephone No _____ Alternative Contact No _____

Occupation _____

Have you been registered with this practice before? Yes No

Reason for wishing to join this practice _____

Lifestyle Information

Height (approx) _____ Weight (approx) _____

Do you take exercise? Light Moderate Heavy

Is your diet (see leaflet) Poor Average Good

Do you smoke? Yes No If Yes how many? _____

Do you use illegal substances? Yes No

If Yes which ones? _____

Do you drink alcohol? Yes No

If Yes how many units per week _____

Family History

Is there any family history of

Asthma Diabetes Cancer Heart Disease Stroke

Other _____

Are you taking any medication at present? Yes No

If Yes please give name of tablets/medicine, strength and how many times a day you take them _____

Do you have any known allergies Yes No

If Yes please give details _____

Date of last tetanus injection if known _____

Date of last Pneumovax injection if known _____

Do you have any disabilities Yes No

If Yes please give details _____

Please turn over

PERSONAL MEDICAL HISTORY

Do you suffer from any of the following conditions?
If **Yes** please give approximate date of diagnosis

Arthritis _____ **Cancer** _____ **Depression** _____
Heart attack _____ **Angina** _____ **Diabetes** _____
Stroke _____ **Epilepsy** _____ **Asthma** _____
High Blood Pressure _____

Have you had any illnesses, accidents or operations in the past? **Yes** **No**

If **Yes** please give details below - continue on a separate sheet if necessary

Details

Approx Date

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Are you under the care of a hospital specialist at present? **Yes** **No**

If **Yes** please give name of specialist, hospital and diagnosis

Women Only

Have you ever been pregnant? **Yes** **No**

Have you had any problems connected with pregnancy **Yes** **No**

If **Yes** please give details and dates _____

Are you using birth control? **Yes** **No**

When was your last smear? _____ Result _____

If aged over 50 years have you had a mammogram? **Yes** **No** Date _____

Nurse/Doctor use only

Urine sample _____ GPs signature _____

Comments _____
