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IN STRICTEST CONFIDENCE

(for office use only:) Recommended/Referred by: /2**019**

NEW PATIENT REGISTRATION DATE: ……..

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

FORENAMES: ……..**.....**

DATE OF BIRTH: ……..... ……

HOME ADDRESS: ……

……..

…… **Postcode**……..……...

CONTACT DETAILS:

Telephone: ……(Home) Mobile: ……

……...(Work) Fax: ……..

Email address:……..
Please **DO / DO NOT** use this email address to communicate medical results

OCCUPATION: ……..

Would you like to receive our Newsletter? (Please circle) **YES / NO**

ALLERGIES TO ANY MEDICATIONS:**.....**

……**.....**

Own General Practitioner:
(If Applicable) ……

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).

……

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……

……

……

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/ Treatment for abnormal periods? NO YES

Have you had any abnormal pregnancies or labours? NO YES

Please state the date of your last smear test and Mammogram if you have had one.

Smear test date: ……

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, Treatment, etc.**
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?	NO	YES	
Rheumatism, painful joints, arthritis, gout, back pain, slipped disc or sciatica	NO	YES	
Stomach pains, constipation, severe vomiting, severe diarrhoea, stomach ulcers, colitis, diverticulitis, piles, rupture or disease of the liver or gall bladder?	NO	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?	NO	YES	
Diabetes, thyroid problems, abnormal hormone levels?	NO	YES	
Significant eye or ear disease?	NO	YES	
Cancer, tumour or malignancy?	NO	YES	
Hepatitis, yellow jaundice, malaria or other infectious diseases contracted abroad?	NO	YES	
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?	NO	YES	
Have you ever had an operation?	NO	YES	
Have you any other past medical problems such as accidents, fractures or out patient investigations not already mentioned?	NO	YES	

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 <u>not</u> to be contacted in this way, please tick here. ☐

I have seen the CMA Charging Statement (Fee transparency letter) ☐

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

Signed: ……

Dated: …….

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

DOCTOR'S NOTES