



Welcome to the Practice

Title	Mr		Mrs		Miss		Other	
Surname					Previous Surname			
Forename					Middle Name (s)			
Address including postcode								
Previous address								
Date of Birth					Contact telephone number			
Contact email address					Have you been registered with us before?			
<p>Your own health Please tell us about any serious illness that you have suffered; any operations you have had and if you are female; any pregnancies (use a separate sheet if necessary).</p>								
<p>Your Family Please tell us about any serious illnesses which have affected any close member of your family. We are particularly interested in High Blood Pressure, Diabetes, Asthma, Heart Attack, Angina and Stroke under the age of 55.</p>								
<p>Do you have any allergies? (Please specify)</p>								
Height					Weight			

Smoking (please tick appropriate response)

- Never smoked tobacco
- Currently smoke
- How many per day?
- Have you stopped smoking?
- When did you stop smoking?
- Currently smoke cigarettes/pipe/cigars (please circle)

Screening and Prevention

If you are female when did you last have a cervical smear?

Alcohol

How many units do you drink each week?

Medication

Please list all medication in full with your current doses, date commenced and reason for using it. (use a separate sheet if necessary).

Please note you will need to see a clinician before any medication is issued by the Practice.

Demographic details: Please tick as appropriate

- White** British Irish Other
- Black** Caribbean African Other
- Asian** Indian Pakistani Chinese Other
- Mixed**
- White + Black Caribbean
 - White + Black African
 - White + Asian
 - Other; please specify

