NEW PATIENT REGISTRATION

Date:_____

Name: _____ **DOB:** _____

Occupation: (please state) _____**student / unemployed/ long term sick**

Emergency Contact Details e.g. family/ friend: Name _____**Relationship**_____ **Telephone No**_____

In Accordance with General Data Protection Regulations do you consent to receiving text messages to your phone: opt in / opt out

If under 18yrs please state school attended _____

Height: _____ **Weight:** _____

Smoking Status: Current smoker / Ex-smoker / Never smoked tobacco (please circle)

Do you exercise? Never, Occasionally or Regularly – light/ moderate/ heavy exercise

Do you have any of the following illnesses? (please circle)

Chronic obstructive airways disease: yes/no **Hypothyroidism: yes/no** **Asthma: yes/no**

Stroke / trans ischaemic attack: yes/no **Diabetes: yes/no** **Epilepsy: yes/no**

Coronary heart disease: yes/no **Hypertension: yes/no** **Cancer: yes/no**

Mental health problems: yes/no

Other significant health problems -

Medication: Are you on any repeat medication? If so please list below:

_____

Please state if you suffer from any drug /food allergies _____

Does your Immediate family have a history of:

Heart Disease: Yes/No **Stroke: Yes/No** **Diabetes: Yes/No** **Other:**

FOR WOMAN ONLY (please circle)

Have you had any pregnancies? Yes **Any children? Yes** **Ages of children?** _____

Have you had a Cervical Smear? Yes **Date of last smear?** _____ **Result** _____

Where was it carried out? previous GP / family planning / abroad / other _____

Family Planning method? **Or name of contraceptive (if used)** _____

Have you had a Hysterectomy? Yes/ No **if Yes – date?** _____