Manor Park Surgery

New Patient Registration

NAME:

Date of Birth:

Address

Home Telephone
Mobile
Please tick to confirm we may use your mobile number to text you ☐

Email Address:
Please tick to confirm we may use your email address to contact you ☐

Ethnic origin:

Are you a carer: Yes/No

Previous medical history (please include any illnesses/operations/accidents):

Medication (please include details of all the medication you are currently taking, or attach old prescription request slip):

Allergies (please include any drugs, foods, pollens etc to which you are allergic):

Is there any FAMILY HISTORY of (please circle as appropriate): -

Asthma / Diabetes / Stroke (CVA) / Heart disease / Hypertension (high blood pressure)

Do you smoke? Yes/No

If Yes please state how many per day …….. cigarettes/cigars/roll your own

Are you an ex-smoker? Yes/No If Yes when did you give up ……

Please complete the following:

1) How often do you have a drink containing alcohol?

   a) Never
   b) Monthly or less
   c) 2-4 times a month
   d) 2-3 times a week
   e) 4 or more times a week

2) How many standard drinks containing alcohol do you have on a typical day?

   a) 1 or 2
   b) 3 or 4
   c) 5 or 6
   d) 7 to 9
   e) 10 or more

3) How often do you have six or more drinks on one occasion?

   a) Never
   b) Less than monthly
   c) Monthly
   d) Weekly
   e) Daily or almost daily

Do you take exercise? Yes/No If Yes is this light/moderate/vigorous

FEMALE PATIENTS ONLY

Have you ever had a cervical smear? Yes/No

Date of your last smear …….. Result of last smear ……..

Was it taken at your GP surgery/Family Planning Clinic/Hospital

Have you ever had a problem smear? Yes/No

Did you have to attend Colposcopy Clinic? Yes/No

Have you had a total hysterectomy? Yes/No If Yes please state date ……..

What method of contraception are you currently using? ……

Are you taking HRT? Yes/No If Yes please state type ……

Signed …….. Date :……