OLD TOWN SURGERY
NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE

Surname: ……..

Forename(s): …….

Date of Birth: …… Marital Status: ……..

Address: ……

…….. Post Code: ……..

Home Tel: …… Mobile: ……..

Do you have any members of your household registered at this surgery? If so, please state patients name: ……..

Are you an ex serviceman/woman? YES/NO

SMOKING :
Do you smoke: Yes/ No
If Yes, How many:
Cigarettes Per Day ……. Cigars Per Day…….
Ounces Of Tobacco Per Day ……
Would you like help to give up? Yes/ No
If so, we will get one of our nurses to contact you
NON SMOKERS:
If you are not a current smoker, have you ever smoked? Yes/ No

ALCOHOL: (Please Circle)

Questions	0	1	2	3	4
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

Would you like to register for the NHS Electronic Prescription Services (EPS)?
If so which pharmacy would you like to nominate

…….

ALLERGIES:
Are you allergic to anything? (Medication/Foods) Yes/No

If Yes, Please give details: ……

FEMALE PATIENTS:
Date of Most Recent Smear: ……

Result of Most Recent Smear: …….

PAST MEDICAL HISTORY:
Please give details of any history of Chronic Diseases
Heart Disease/Atrial Fibrillation? Yes/No
Stroke? Yes/No
Cancer? Yes/No Site of Cancer …….
Diabetes? Yes/No
Asthma? Yes/No
Epilepsy? Yes/No
High blood pressure? YES/NO
Chronic lung disease (e.g. COPD)? YES/NO
Chronic Kidney disease? YES/NO
Mental Health problems? YES/NO

FAMILY HISTORY:
Is there a history of any of the above conditions in your family before the age of 65?
If so, please give details
……..

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MEDICATION:
Please give details of any Medication that you take regularly
……

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ARE YOU A CARER? ARE YOU BEING CARED FOR BY SOMEONE ELSE? If yes, please give details
……..