

# Haverthwaite Surgery - New Patient Information Sheet

Please complete and hand to the receptionist with your completed registration form.

## Patient Information

Name

Date of Birth

Address

Post code

Home Telephone

Mobile No

Email address

Preferred Method of Contact:      telephone, mobile, email, post

Do you need information in any special format?

.....

Ethnicity

Occupation

Marital Status:

Are you a registered Carer.    Yes / No

.....

## Next of Kin

Name

Address

Relationship to patient

Date of Birth

Contact Number

Are you a registered carer?    Yes / No

Do you have a carer?    Yes / No

Do you have a social worker?

(Please give details)

Are any other health professionals involved in your care?

(Please give details)

Who has parental responsibility for you?

(Please give details)

## Medical History

1. Are you in good general health? Yes/No
2. Have you been a hospital patient in the last year? Yes/No
3. Have you been in prison prior to registering with the practice Yes/No
4. Are you allergic to penicillin, codeine, aspirin or any other medication? Yes/No  
If yes please list:
  
5. Do you smoke cigarettes? How many a day? .....
6. How much alcohol do you have per day? .....
7. Do you have a special diet? Give Details.

Are you currently taking medication? If yes please list. Yes/No

Do you give your permission for the practice to discuss your detailed medical records with your next of kin (results / consultations etc. ) Yes / No

## Current Medical Conditions

Please circle if you have had any of the following problems:

Stroke/TIA; Mental Health; Seizures; Hypertension; Heart Disease; Asthma; COPD/Emphysema; Tuberculosis; Anaemia; Arthritis; Prostate Problems; DVT/Blood Clots; Cancer; Diabetes; Thyroid Disease; Osteoporosis.

Family History: Do your family members have a history of any of the following diseases:

Hypertension; Heart Disease; Diabetes; High Cholesterol; Asthma; Arthritis; Glaucoma; Cancer; Thyroid Problems; Osteoporosis.

Any other information you feel is appropriate for the doctor to know please add below.

*Thank you for completing this questionnaire.*