OLD TOWN SURGERY
NEW PATIENT REGISTRATION / HEALTH QUESTIONAIRE

Surname	
Forename(s)	
Date of Birth	
Address	
Post Code	
Home Tel	
Mobile Tel	

Do you have any members of your household registered at this surgery? If so please state patient's name:

ALLERGIES
Are you allergic to anything? (Medication / Foods) If so please provide details

PAST MEDICAL HISTORY
Please provide any history of Chronic Diseases

Heart Disease?	Yes / No	
Diabetes?	Yes / No	
Asthma?	Yes / No	
Stroke?	Yes / No	
Cancer?	Yes / No	Site of Cancer

FAMILY HISTORY
Is there a history of any of the following in your family before the age of 65?

Heart Disease?	Yes / No	Family Member
Diabetes?	Yes / No	Family Member
Asthma?	Yes / No	Family Member
Stroke?	Yes / No	Family Member
Cancer?	Yes / No	Family Member
Site of Cancer		

MEDICATION
Please provide details of any Medication that you take regularly