OLD TOWN SURGERY
NEW PATIENT REGISTRATION / HEALTH QUESTIONAIRE

Surname	
Forename(s)	
Date of Birth	
Marital Status	
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:

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? If so we will get one of our nurses to contact you	Yes / No

NON SMOKERS:

If you are a non smoker, have you ever smoked?	Yes / No

FEMALE PATIENTS:

If known please provide details of your most recent cervical smear test

Date of smear	
Result	
Recall	

ALCOHOL

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

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
