NEW PATIENT REGISTRATIONS

Have you been registered at this practice before?\_\_\_\_

|  |  |
| --- | --- |
| NAME |  |
| ADDRESS |  |
| **DOB** | **TELEPHONE NO** |
| PAST MEDICALHISTORY |  |
| MEDICATION |  |

|  |  |
| --- | --- |
| **LAST SMEAR** |  |
| **IMMUNISATIONS** |  |
| **ALLERGIES** |  |

# SOCIAL HISTORY

|  |  |
| --- | --- |
| MARITAL STATUS | OCCUPATION |
| SMOKING HISTORY – please circleNEVER/CURRENT OR EX SMOKER | ALCOHOL |
| EXERCISE | NUMBER OF CHILDREN |
| ARE YOU A CARER? YES/NO | DO YOU HAVE A CARER? YES/NO |

**FAMILY HISTORY**

|  |
| --- |
| IHD (under or over 60) |
| Cerebrovascular disease |
| Asthma |
| Diabetes |
| Other |

|  |  |
| --- | --- |
| **WEIGHT** | **HEIGHT** |
| **BP** | **WAIST** |

**I give consent to be contacted by The Charleston Surgery via text**

**Signed Date**