Saideman Practice - Registration form

Please complete this Registration Form prior to your first consultation. Thank you.

Personal Details:		
Title:	First name:	Last name:
Date of Birth: ____/_____/_____	Sex: Female _____ / Male_____	Nationality: Occupation:
Address: Postcode:		
Home Phone:	Mobile phone:	E-mail:
NHS GP Name and Address Tel:	Postcode:	Do you have private medical insurance? Yes _____ / No_____ Name:

Emergency Contact Details:		
Name:	Relationship to you:	
Address: Postcode:		
Home Phone:	Mobile phone:	E-mail:

Medical History:		
Are you currently receiving treatment from a doctor, hospital or clinic?	Yes__/No___	Give details:
Do you see any consultants on a regular review basis?	Yes__/No___	Give details:
Do you have any allergies to medicine (eg. Penicillin) substances or food, hay fever?	Yes__/No___	Give details:
Are you currently taking any prescribed medicines (eg. tablets, injections, or inhalers)?	Yes__/No___	Give details:
Are you currently carrying any medical warning card?	Yes__/No___	Give details:
Do you smoke?	Yes__/No___	Give details (how many cigarettes a day):
Are you an ex-smoker?	Yes__/No___	Give details (date stopped):
Do you drink alcohol?	Yes__/No___	Give details (eg. Units a day or week): (A unit is half a pint of lager, a single measure of spirit or a single glass of wine)

Have you ever suffered from:		
Heart problems (eg. heart attack, angina, blood pressure, stroke, atrial fibrillations, pace maker or thrombosis)?	Yes__/No___	Give details:
Chest problems (eg. bronchitis, asthma, TB, pneumonia)?	Yes__/No___	Give details:
Fainting attacks, giddiness, blackouts, epilepsy, headaches, migraines or memory problems?	Yes__/No___	Give details:
Diabetes or thyroid problems?	Yes__/No___	Give details:
Liver problems (eg. jaundice, hepatitis or gall stones)?	Yes__/No___	Give details:
Digestion / bowel problems (eg. stomach ulcers, Crohn's, colitis, coeliac, IBS, diverticulitis)?	Yes__/No___	Give details:
Kidney problems?	Yes__/No___	Give details:
Mental health problems (eg. anxiety, depression)?	Yes__/No___	Give details:
Bone or rheumatology problems (eg. osteoporosis, fractures, arthritis, SLE)?	Yes__/No___	Give details:
Skin problems (eg. eczema, psoriasis)?		
Cancer?	Yes__/No___	Give details:
Any other serious illness, fractures, operations, procedures?	Yes__/No___	Give details:

Is there anyone in your family who has had:		
Heart problems?	Yes__/No___	Give details:
Chest problems?	Yes__/No___	Give details:
Epilepsy?	Yes__/No___	Give details:
Diabetes or thyroid?	Yes__/No___	Give details:
Liver, bowel or kidney problems?	Yes__/No___	Give details:
Mental health problems?	Yes__/No___	Give details:
Osteoporosis or fractures?	Yes__/No___	Give details:
Cancer?	Yes__/No___	Give details: