Drs Schmalhorst & Stokes
'Plas Meddyg' Surgery, 40 Parkhill Road, Bexley, Kent, DA5 1HU

1. **REGISTRATION DETAILS for adults**

SURNAME .... Married/Single/Divorced/Widowed/Partnered
FORENAMES ....
MAIDEN / FORMER NAME..
ADDRESS...……………………..POSTCODE...............
TEL......................................(Home) ....(Mobile) ……………………….(Work)
e.mail address………………………………………………………………
DATE OF BIRTH........................... OCCUPATION.............................ETHNICITY…………

2. **SMOKING**: Do you smoke? Yes/No/Ex Cigarettes/Cigars/Pipe. How many per day? ....

3. **ALCOHOL**: Do you drink alcohol? Yes/No. How much per week? ....

4. **EXERCISE**: Do you take regular exercise? None/Gentle/Moderate/Vigorous

5. **LEISURE ACTIVITIES**: Include D.I.Y. ....…...

6. Please measure your **HEIGHT? .... WEIGHT? ....WAIST?.................**

Now please calculate your body Mass Index (BMI) which is your Height (metres) x Height (metres) x Weight (kilogrammes). BMI……….
If your BMI is above 30, would you like an appointment with the nurse who can refer you to a Lifestyle Style Programme (You must answer this question). YES………… NO……………

7. Do you have any **CURRENT/PAST ILLNESS**? Yes/No. Please give details

....

....

....

8. *MEDICATION**:*** *Please give full details of any tablets/medications taken regularly* ***and <u>please bring your repeat prescription slip from your previous doctor with you when returning these form so that we can photocopy it</u>***

....
....
……………………………………………………………………………………………..

9. Do you suffer from any **ALLERGIES TO MEDICINES**? Yes/No.
   Details...

10. (Nurse Only Info)…Urine dip……Glucose………..Protein………….Blood……………..
    Advice given……………………………………………………………………………...

11. Have you had a **TETANUS VACCINATION** in the last 10 years? Yes/No
    Date..

12. Do you have **PRIVATE HEALTH INSURANCE**? Yes/No Name....................................

13. **FAMILY HISTORY**: If you, or your family, have a history of the following conditions, could you please tell us as what age the problem developed:

High blood pressure	Diabetes	Asthma
Stroke	Heart disease	High cholesterol
Thrombosis	Migraine	Thyroid
Hay fever	Eczema	

    If deceased, age at death and cause ....

14. **FEMALE PATIENTS ONLY**

    (a) Please give details of your last CERVICAL SMEAR:
    Date........................... Place .... (Doctor's surgery/clinic)

    (b) Have you had a MAMMOGRAM (breast scan)? Yes/No
    Date........................... Place ....

    (c) Present method of contraception (if applicable) ....

    (d) How many pregnancies? Give dates and any problems incurred by yourself or baby or miscarriage...
    ....

15. **NEXT OF KIN/CARER DETAILS:**

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…………………………………………………………………………………………………

Please complete the following:

1. I do/do not give permission for my prescriptions to be collected by a member of my family.

2. I do/do not give permission for messages to be left on my telephone for me.

3. I consent for the following person (carer / family member) to have access to my medical records and deal with repeat prescriptions / test results / referrals / medical advice.

   Carer/Family Member's Name ……………………………………………………………

Patient's signature ……………………………………… Date……………………………