Cos Lane Medical Practice

New Patient Health and Registration Information

Surname	
First Name(s)	
Date of Birth	
Mobile Telephone No.	
Email Address	
Occupation	
What is your first language?	
Do you need an interpreter?	YES / NO
Are you registered disabled? (if yes please give details)	YES / NO
Are you a military Veteran?	YES / NO
Do you have a carer? (if yes please give details)	YES / NO
Are you a carer? (if yes please give details)	YES / NO

Next of kin:- Please give name, address, telephone number and relationship to you of your next of kin?

Do you hold a living will, an advanced care directive or a DNACPR? (documentation regarding your personal wishes in respect of medical intervention at the time of serious illness) If yes, please supply a copy.	YES / NO

Have you granted Power of Attorney to a family member or friend? If yes, please supply a copy.	YES / NO

Have you received a blood transfusion prior to 1996? (If yes please confirm if you have been previously tested for Hepatitis C?)	YES / NO

Family Medical History :- Please state any serious illness, in particular cancer, heart disease, stroke, high blood pressure, diabetes, or any inherited disease. Please state your relationship to the individual and in the case of cancer, the type of cancer.

PERSONAL MEDICAL HISTORY

Have you ever suffered from?

Epilepsy	YES / NO	Blindness / Glaucoma	YES / NO
High Blood Pressure	YES / NO	Diabetes	YES / NO
Heart Attack / Stroke	YES / NO	Asthma	YES / NO
Cancer	YES / NO	COPD	YES / NO
Depression	YES / NO	Eczema/Hay Fever	YES / NO
Other Mental Health problem	YES / NO	Any other serious illness	YES / NO

If yes to any of the above, please state the year(s) when you were first diagnosed?

Also please list any additional serious illnesses, operations, accidents,disabilities, (and for women any pregnancy related problems) and the year they took place.

Please list any medicines that you are taking and the amount and attach a copy of your medication re-order slip if you have one.

PLEASE BRING IN ALL MEDICINES AND PACKAGING WHEN YOU ATTEND YOUR FIRST GP CONSULTATION.

Are you allergic to any medicines?

YES /NO if yes, please give more details?

HEALTH PROMOTION

What is your height?		What is your weight?	

Smoking and Vaping

Do you vape?	YES / NO
Do you smoke?	YES / NO
If no have you ever smoked?	YES / NO
If you currently smoke, how many cigarettes or ounces of tobacco do you smoke per week?	
Would you like advice on giving up smoking or vaping?	YES / NO

Alcohol

How many units of alcohol do you drink per week?	

I confirm that all the above details are correct.

I would like to sign up to Online Patient Services, (ordering prescriptions and booking of appointments online) please send me registration details.

I would like to sign up to text reminder services and messages.

I accept that it is my responsibility to keep the surgery informed of all changes to any of my contact details.

Signed		Date	

Nov-24