Woodhall Farm Medical Centre

Valley Green Woodhall Farm Hemel Hempstead Hertfordshire HP2 7RJ
Tel: 01442 261805 Fax: 01442 261750

Patient Registration Form

Title ……… Surname …………………….……… First Names ……………………………………..

Date of Birth ……………………………………..… Previous Surname ………………………………

Home Address ………………………………………………………………………..…..……..

………………………………………………………………………Postcode...…………….…………

Home Telephone ……………………….…… Work Telephone ………………………………………

Mobile Number ………………………………… Email Address ………………………………………..

What is your height?	
What is your weight?	
What is your first language?	
How much exercise do you do? Please tick one.	None: Light: Moderate: Strenuous:
What diet do you have? Please tick one.	Normal: Vegetarian: Weight reducing: Pescetarian: Vegan: Other (please specify):
Do you speak English?	Good / Poorly / Not at all

Ethnic Group – please tick as appropriate			*If other please specify*
White	British	Irish	Other
Black	Caribbean	African	Other
Asian	Indian	Pakistani	Other
Chinese			Other
Mixed	White & Black Caribbean		
	White & Black African		
	White & Asian		
Other			

Medical Information

Please list any serious illnesses/operations/accidents/disabilities (and for women, any pregnancy related problems) and the year they took place:

Name and Address of Previous GP

Name:

Address:

If you have arrived from abroad, please state the date you arrived, what country you came from and where you were born:

Date arrived in the UK:

Country of origin:

Town and country of birth:

Medical Information

Have you ever suffered from? (Tick and delete as appropriate)

Epilepsy	Yes No	Blindness/Glaucoma	Yes No
High Blood Pressure	Yes No	Diabetes	Yes No
Heart Attack/Stroke	Yes No	Depression	Yes No
Cancer	Yes No	Asthma	Yes No
Eczema/Hay Fever	Yes No	COPD	Yes No

Please list any medications you currently take including the dosage (strength, amount and how often taken):

Are you registered disabled? (if yes, please give details) Yes / No

Are you allergic to any medicines and if so, which? Yes/ No

Do you have any other allergies, if so please describe? Yes / No

Have you ever suffered from? (Tick as appropriate)

Anxiety	Yes / No	Depression	Yes / No
OCD	Yes / No	Bipolar Disorder	Yes / No

Do you have any other mental health issues, if so please give details?

Are you receiving or have you ever received any treatment or therapy? (Please give details)

Carers:

(Please see Notice Board and Leaflets in the Waiting Room for Carers information). Examples of carers are mother of disabled child, son or daughter looking after elderly parent who cannot manage without you, wife of habitual drug user.

Do you have a carer? (If yes please give details) Yes / No

Are you a carer? (If yes please give details) Yes / No

Do you hold a Living Will? Yes / No

(A Living Will is documentation regarding your personal wishes in respect of medical intervention at the time of serious illness)

Women:

Have you ever had a Cervical Smear? Yes / No

If "yes" please state when and where ______________________________________

Smoking:

Do you smoke? Yes / No

If "No", have you ever smoked? Yes No

If you do currently smoke, how many cigarettes or packs of tobacco do you smoke per week?

Would you like advice on giving up smoking? Yes / No

Alcohol:

Do you drink alcohol? Yes / No

How much do you drink a week?

(For example, one large glass of red wine, three cans of low strength cider and two bottles of high strength beer.)

Family History

Please state any serious illness, in particular heart disease, strokes, high blood pressure, diabetes or any inherited diseases

Next of Kin and what relationship they have to you (ie husband or wife, partner etc.)

Please give name, address and telephone number of next of kin and Relationship to you.

For patients aged 65 and over or those with a chronic disease (e.g. asthma or diabetes)

Have you had a flu vaccination? Enter date or “never”

Have you had a Pneumococcal vaccination? Enter date or “never”

PLEASE NOTE YOUR REGISTERED GP WILL BE DR K MIRZA, BUT YOU MAY BE SEEN BY ANY OTHER GP WHEN YOU MAKE AN APPOINTMENT

CONSENT: We will not be able to pass on information about you to family or friends if you are over 16 years without your express written consent. If you are under 16 we will not share information on your sexual health without your written consent unless the doctor feels not to do so would put you at risk.

SHARING CONSENT: By signing this document you are giving permission for your Summary Care Record which includes information regarding any allergies, major illnesses and repeat medication details to be shared with local NHS organisations i.e. Hospitals. If you do not wish this information to be shared please indicate at the bottom of this form.

Name ……………………………………………… Date ………………………………………………..

Signature …………………………………………..