# BRIDGE HOUSE MEDICAL PRACTICE

## Registration Document
## Personal details for Purpose of registration

## New patient health Questionnaire

| | | |
|---|---|---|
| Title: | Date of birth: | Sex: |
| First names: | Family name: | NHS Number: |
| Address:<br><br><br>Post code: | Country of origin:<br><br>Main language spoken: | Home Telephone number<br><br>Mobile number |
| Email: | Height: | Weight: |
| Next of kin name: | Next of kin telephone number: | How would you describe your ethnicity? |

| Please tick anything that applies to you | | | | | |
|---|---|---|---|---|---|
| I have never smoked | | I am an ex smoker | | I currently smoker | |
| I take part in heavy exercise most days | | I exercise at least twice a week | | I occasionally exercise | |
| I walk most days | | I do not like to exercise | | I am unable to exercise | |
| I am Tee total I never drink | | I drink daily | | ! drink occasionally | |

| Have you had any of the following please give dates | | | | | |
|---|---|---|---|---|---|
| Heart attack | | Cancer | | Rheumatoid Arthritis | |
| Stroke | | Heart failure | | HIV/ AIDS | |
| Diabetes | | Asthma | | Sickle cell | |
| High blood pressure | | COPD | | | |
| Epilepsy | | Kidney disease | | | |

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| Have you have any of the following vaccines | | | |
|---|---|---|---|
| Polio | | Hepatitis B | |
| MMR | | BCG | |
| Pneumoccocal | | Rubella | |
| Tetanus | | Hepatitis A | |

| Your Medical History |
|---|
| Any serious illness (and date) |
| Drug Allergy or Other Allergy: |
| Any disability |
| Any medication |
| Do you have a carer Y/N?<br><br>Carers details: |

**Family Medical History**

Please indicate which member of your family has had any of the following e.g. Mother, Father sister, brother etc.

| | | | | | |
|---|---|---|---|---|---|
| Asthma | | Cancer | | Thyroid | |
| Heart disease | | High Blood pressure | | Diabetes | |
| Stroke | | Epilepsy | | Other | |

**Females Only**

Reviewed
October 2018

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| Smear Information | |
|---|---|
| I am below the age of 25 and have not started to have regular smears | |
| I have regular smears | |
| My last smear was taken on (please provide date) | |
| My latest smear result was (please tick below) | |

| Normal | | Abnormal | | Inadequate | |
|---|---|---|---|---|---|

| Mammogram Information | |
|---|---|
| I am over the age of 50 | Y / N |
| I had my last mammogram (please provide date) | |
| My latest mammogram result was (please tick below) | |

| Normal | | Abnormal | | Inadequate | |
|---|---|---|---|---|---|

| Contraceptives<br>**I am using** | | | | | |
|---|---|---|---|---|---|
| Oral contraceptives the Pill | | Depo injections | | Cap/ Diaphragm | |
| Patches | | condoms | | I do not use contraception | |
| Implants | | Coil | | I am currently pregnant | |
| | | | | Cap/ Diaphragm | |

| | |
|---|---|
| Do you want to have access to our Online Services? (if YES , please ask at reception to be registered ) | |
| Do you allow us to share your record with other health professionals ( e.g. Hospitals , community services, etc. ) if needed ? | |

Reviewed
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