PENSILVA HEALTH CENTRE - NEW PATIENT REGISTRATION

Surname			Firstname		
Date of birth			Tel. No.		
Marital Status	Single ❑	Married ❑	Divorced ❑	Separated ❑	Widowed ❑
Next of Kin:			Contact No.		
What is your present Occupation?					
What previous occupations have you had?					
Do you currently smoke? Yes / No	If yes, how much per day? Cigarettes_____ Cigars_____ Pipe (oz)_____				
Have you ever smoked? Yes / No	If yes, date stopped smoking? _____ How much did you smoke? _____/ day				
How often did you have a drink containing alcohol in the past year?	Never ❑	Monthly or less ❑	2 - 4 times a month ❑	2-3 times a week ❑	4 + times a week ❑
How many drinks did you have on a typical day when you were drinking in the last year?	1 or 2 ❑	3 or 4 ❑	5 or 6 ❑	7 - 9 ❑	10 + ❑
How often did you have 6 or more drinks on one occasion in the past year?	Never ❑	Less than monthly ❑	Monthly ❑	Weekly ❑	Daily or almost daily ❑
Do you take regular exercise? Yes/No	Do you have a balanced diet? Yes/No				
Weight:	Height:				

Have you been immunised against: (insert date of immunisation)

Diphtheria ❑	……	Tetanus ❑	……	Polio ❑	……	Whooping Cough ❑	……
Measles ❑	……	Mumps ❑	……	Rubella (German Measles) ❑	……	BCG ❑	……

PAST ILLNESSES

What illnesses have you had in the past? (when/what)

What operations have you had? (when/what)

Have you a disability?

Have you any allergies? Yes/No What drug(s)?

What happens?

Please state what tablets or medicines you take from the doctor or hospital?

Drug name (include strength)	Regularly	Occasionally
	❑	❑
	❑	❑
	❑	❑
	❑	❑
	❑	❑

Have you any medical problems at present?

Have you any problems that it might help your doctor to know about in your personal life (your childhood, your education, your family or home life or your accommodation)?

FAMILY HISTORY

Have any relations had any of the following: (Tick as appropriate)

Tuberculosis	❑	Diabetes	❑	High Blood Pressure	❑	Heart Attack	❑
Stroke	❑	Asthma	❑	Hay Fever	❑	Migraine	❑
Depression	❑	Cancer	❑	Epilepsy	❑		

If so, please give details below:

WOMEN

Births: (Dates)	Complications of Pregnancy	Problems of Delivery	Birth weight
1.			
2.			
3.			

Miscarriages: (Dates)	How many months	Womb scraped?
1.		
2.		
3.		

Have you had a mammogram?	Yes/No	When did you last have a cervical smear?
Are you on the pill?	Yes/No	Name:
Age when periods stopped?		

ADDITIONAL INFORMATION (please continue over if required)