PENSILVA HEALTH CENTRE - NEW PATIENT REGISTRATION

Surname			Firstname					
Date of birth			Γel. No.					
Marital Status	Single	Married	Divorced	Separated	Widowe	ed		
Next of Kin:			Contact No.					
What is your present Occup	nation?		contact 110.					
What previous occupations								
Do you currently smoke?	Yes / No	If yes, how mu	uch ner day? (Cigarettes	(Cigars	Pipe (oz)	
Have you ever smoked?	Yes / No		pped smoking?			ch did you si		ay
How often did you have a d			Monthly of		imes a	2-3 times a	4 + times a week	_
alcohol in the past year?		Never 🖵	less 🗖	month		week \Box		CK
How many drinks did you h day when you were drinkin			3 or 4 🗖	5 or 6		7 - 9 🗖	10 + □	
How often did you have 6 cone occasion in the past year		n Never 🗆	Less than monthly	Montl	nly 🗖	Weekly 🗖	Daily or almost daily	t
Do you take regular exercise		Ī	Do you have a b		? Yes/No)	<u> </u>	
Weight:	C. 105/110		Height:	ununcea aret	. 105/140	,		
Have you been immunised	against: (insert							
•					Whoopi	nσ		
Diphtheria □	Tetanus 🗖	•••••	Polio 🗖		Cough [
			Rubella					
Measles □	Mumps \Box	,	German		BCG 🗖	•••••		
			Measles)	_				
			ST ILLNESSES	8				
What illnesses have you have	d in the past? (when/what)						
What operations have you h	nad? (when/wha	it)						
Have you a disability?								
	0.7 YYY	() 2						
Have you any allergies? You	es/No What dru	ıg(s)?						
What happens?								
Please state what tablets or		take from the do	octor or hospital	?				
		take from the do	octor or hospital	?	Regular	ly	Occasionally	
Please state what tablets or		take from the do	octor or hospital	?		ly		
Please state what tablets or		take from the do	octor or hospital	?		ly		
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Please state what tablets or Drug name (include strengt	h)		octor or hospital	?		ly		
Please state what tablets or Drug name (include strengt	h) lems at present	? your doctor to k						ur
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