### Springfield House Medical Centre

### New Patient Information

Have you been registered with this practice before? 🞎 Yes 🞎 No

### Patient’s Details

Miss / Ms / Mrs / Mr Male / Female Marital Status ………………

Surname ……………………… Forename………………………… Date of birth / /

Address …………………………………………………………………………………………

 …………………………………………………………………………………………

Post Code ………………… Occupation …............................................................................

Telephone numbers Home:……………Work:…………….. … Mobile……………………….

What is your first language? …………………… What is your ethnicity? ….................................

Are you a member of the armed forces? ……………………………………………………………

Have you ever been a member of the armed forces? ………………………………………………..

Are you happy for this to be on your records? ……………………………………………………….

# Medical History

**Smoking Status:** Never Smoked 🞎 Smoker 🞎 (how many a day): Ex Smoker🞎

**Alcohol Intake:** Lifelong Teetotaller 🞎 Currently Drinks 🞎 (Units per week ) Ex-Drinker 🞎

**Medication:** What medicines are you taking? …………………………………………………………..

**Allergies:** Do you have any allergies to medication or anything else?......................................................

Do you have a hearing impairment?………………………………………………………………….

Do you have a sight impairment?...............................................................................................................

Do you have any serious medical illnesses/conditions? ……………………………………………...

Have you ever had any operations? …………………………………………………….……………..

Do your blood relatives have any serious illnesses/conditions? ……………………………………

Are you a carer for anybody? Please give details ……………………………………………………..

Do you have a carer? Please give details ……………………………………………………………….