

Pre-registration Health Assessment Form

Personal Details

Note: All information given on this form is added to your medical record

Your surname

Forename(s)

Address

.....

Postcode

Contact numbers
(House & Mobile)

Email address

Is your address? House
Tick as appropriate Flat
 Bedsit
 Hall of Residence
 Other

Is this address? Rented Owned

Your date of birth

d	d	m	m	y	y
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Town and country of birth

Ethnic group

Your occupation

If you are a student, please supply name of college, course name and end date of course

Are you? Single
Tick as appropriate Married
 Separated
 Divorced
 Widowed
 Other

Previous surname

If appropriate

If you have children, please give details of each below:

Name	Gender	Date of Birth						
.....	<input type="checkbox"/> m <input type="checkbox"/> f	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td>d</td><td>d</td><td>m</td><td>m</td><td>y</td><td>y</td></tr></table>	d	d	m	m	y	y
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d	d	m	m	y	y			

Your Health

Do you smoke? No
 Yes cigarettes per day

Do you drink? No
 Yes units per week

What is your approximate height?

What is your weight?

If you are female, have you had a Cervical Smear test?
 No Yes

Was this test undertaken abroad?
 No Yes

Females who are 20 years and over and are sexually active are advised to have a smear test every three years.

Do you take routine medication? No Yes
e.g. oral contraception, blood pressure tablets etc.

If yes, please give details:

Drug Name	Dose	Times/Day
.....
.....
.....
.....

Are you allergic to any medication that you know of?
e.g. Penicillin No Yes

If yes, what?

Have you ever misused drugs? No Yes

If yes, which drug(s)?

How often?

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Medical History

Have you ever suffered from the following?

Condition (tick as appropriate)	What year(s)?
<input type="checkbox"/> Heart attack
<input type="checkbox"/> Angina
<input type="checkbox"/> Stroke
<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Thyroid disorder
<input type="checkbox"/> Cancer
<input type="checkbox"/> Asthma
<input type="checkbox"/> Depression
<input type="checkbox"/> Mental health problem
<input type="checkbox"/> Dementia
<input type="checkbox"/> Tuberculosis (TB)
<input type="checkbox"/> Jaundice
<input type="checkbox"/> Skin disease
<input type="checkbox"/> Stomach ulcer
<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Hay fever
<input type="checkbox"/> Malaria

Please give details of any operations you have undergone

Please specify and give approximate year (e.g. hysterectomy, 1992)

.....

Have you had any other significant illnesses?

Please specify and give approximate year (e.g. tetanus, 1977)

.....

Carers

Are you a carer? No Yes

For whom do you care?

Is this person registered here? No Yes

Do you have a carer? No Yes

Please provide details for your carer:

Name

Contact Number

Family History

Please provide us with information on the general health of your family

Your parents	Age	State of health
Father
Mother

Your bothers and/or sisters

Gender	Age	State of health
<input type="checkbox"/> m <input type="checkbox"/> f
<input type="checkbox"/> m <input type="checkbox"/> f
<input type="checkbox"/> m <input type="checkbox"/> f
<input type="checkbox"/> m <input type="checkbox"/> f

Are there any family illnesses? if so, please give details

e.g. heart problems, diabetes etc.

.....

Signed

Date

Please inform reception if you have any preferences regarding your GP. Remember that an appointment with a specific GP is subject to availability. We invite you to attend a consultation with the practice nurse to discuss health issues.

Please bring this completed for with you when you register at the practice