REGISTRATION FORM

TITLE: .....NAME ..... DATE OF BIRTH: .....
ADDRESS:.....
.....POST CODE: .....
TELEPHONE: ..... MOBILE:
..... EMAIL: .....
HOW DID YOU HEAR ABOUT US? .....
OCCUPATION: .....
GP NAME AND ADDRESS: .....
..... POST CODE: .....

Are you currently receiving treatment from a doctor, hospital or a clinic?	YES / NO
Are you currently taking any prescribed medications? (PLEASE GIVE DETAILS BELOW)	YES / NO
Are you pregnant or possibly pregnant?	YES / NO
Do you carry a medical warning card?	YES / NO
Do you suffer with or have you ever had:	
Allergies from any medicines/foods? (e.g. Penicillin)	YES / NO
Diabetes?	YES / NO
Hay fever or eczema?	YES / NO
Fainting attacks, giddiness, blackouts or Epilepsy?	YES / NO
Bronchitis, asthma or other chest condition?	YES / NO
Arthritis?	YES / NO
Persistent bleeding following injury, tooth extraction or surgery?	YES / NO
Any heart problems, angina, blood pressure problems, stroke or pacemaker?	YES / NO
Any infectious diseases? (Including HIV/Hepatitis?)	YES / NO
Have you ever had:	
A bad reaction to general or local anaesthetic?	YES / NO
Rheumatic fever?	YES / NO
Liver disease (E.g. jaundice, hepatitis) or kidney disease?	YES / NO
Any other serious illness?	YES / NO
Blood refused by the Blood Transfusion Service?	YES / NO
A hip or joint replacement or other implant?	YES / NO
Heart surgery?	YES / NO
Brain surgery?	YES / NO
What is your average **weekly** consumption of alcohol? ..... UNITS	
If you smoke, what is your average per **week**? ..... CIGARETTES	

If you have answered YES to any of the above please give us details, including any MEDICATION:

If I am unable to speak/receive or read any correspondence , I authorise the Practice to communicate with: