CLARENCE MEDICAL CENTRE

Patient Questionnaire

Please give full details to help us give you a better service. Please be aware that once you have registered, there may be a delay before your medical records reach us from your previous surgery.

Title:	Mr ❒ Mrs ❒ Miss ❒	**Address:**	
	Other (please state)		
Surname:		**Postcode:**	
Forename(s):		**Home Tel:**	
Date of Birth:		**Mobile:**	
Gender:	Male ❒ Female ❒	**Email:**	
Height:		**Ethnic Origin:**	
Weight:		**First Language:**	

Next of Kin:		**Relationship:**	
Address:		**Telephone No:**	
		Mobile:	

Are you allergic to any medication?	Yes ❒ No ❒	**If yes, please give details**	
Do you have any other allergies?	Yes ❒ No ❒	**If yes, please give details**	
Last smear test date:		**Result:** *(if known)*	

Have you ever suffered from any of the following? If yes, tick box and include date of diagnosis.

Asthma / Bronchitis	❒	Date:	Epilepsy	❒	Date:
Hayfever	❒	Date:	Mental Illness	❒	Date:
High Blood Pressure	❒	Date:	Diabetes	❒	Date:
Heart Disease	❒	Date:	Any other severe illness	❒	Date:
Jaundice	❒	Date:	Major injury/trauma	❒	Date:
Kidney Problems	❒	Date:	Major operation	❒	Date:

FAMILY HISTORY – do any of the **above** run in the family? If yes, please indicate below:

Current Medication: Please list any current medication you are prescribed (including the contraceptive pill)

Smoking: **SMOKER** Yes ❒ No ❒ How many per day: _____ **Ex-Smoker** ❒ Date stopped:_____

Alcohol: Currently drink alcohol ❒ Ex-drinker ❒ Teetotal ❒

How many units: Per day _____ Per week _____

Signed: **Date:**