

**DRS IMOGEN BATTERHAM, ANDREW SMITH, JULIAN TREADWELL & SAM ROBINSON**

**New patient registration form**

We would be grateful if you could complete the questionnaire below as fully as possible. Thank you.

Personal details						
First Name:		Surname:			Date of birth:	
					Male <input type="checkbox"/> Female <input type="checkbox"/>	
Home telephone number:		mobile:				
Email address:						
Home address:						
Ethnic origin (please select from list provided at reception):						
First Spoken Language:						
Marital status:		Children:				
Occupation:						
Other details						
What is your approximate height? [       ] and Weight? [       ]						
Do you smoke? <input type="checkbox"/>		When did you stop smoking?			How many do you smoke daily?	
Do you take regular exercise? Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Light exercise <input type="checkbox"/> Moderate exercise each day <input type="checkbox"/> Invalid <input type="checkbox"/>						
Alcohol						
What is your average intake of alcohol per week (in Units)? [       ] (1 unit is approx 1 glass of wine, ½ pint of beer, 1 pub measure of spirits)						
	0	1	2	3	4	Score
How often do you have a drink that contains alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-8	9-10	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Medical History						
Is there any history of a significant illness in your family? (eg High blood pressure, heart disease, stroke, heart attack, diabetes, asthma, thyroid problems, cancer). If yes, please specify:						
Do you have any medical problems at present?						
Are you currently taking any medication? Please list below:						
Have you had any serious illnesses, operations or accidents in the past? Yes/No						
If "YES" please give details:						
Do you have any allergies? (including medications):						
Please give the date of your last tetanus injection (if known):						
Ladies – Please give the date of your last cervical smear:						