NEW PATIENT INFORMATION SHEET

PATIENT DETAILS

Name _____ **Date of Birth**_____

Address _____ **Telephone Number**_____

_____ **Occupation**_____

_____

NEXT OF KIN

Name_____ **Telephone Number**_____

Address _____ **Relationship** _____

_____ *** If you are registering a child under 16 please let us know if you want to receive text reminders for their appointments.***

YES □ NO □

Previous doctor _____

Address of Practice _____

PAST MEDICAL HISTORY

_____

Have you had a Blood Transfusion BEFORE 1996? Yes/No

MEDICATION

Please state any treatment you are on at present

_____

_____

FAMILY HISTORY

Have parent or near relatives ever suffered from:

HEART DISEASE_____ **STROKE**_____

HIGH BLOOD PRESSURE_____ **DIABETES**_____

(Please state relationship to yourself)

LIFESTYLE: SMOKING _____PER DAY ALCOHOL_____PER WEEK EXERCISE_____PER WEEK

ALLERGIES

NEW DATA PROTECTION LAW

We use various systems to communicate with you regarding your health and under the new General Data Protection Regulation Guidelines we can continue to do this if it relates to your health. We may also contact you regarding your appointments, general health campaigns and to share practice information. This could be via text message, email, letter or phone

Please tick all options indicating how you wish the practice to communicate with you:

Text Message □ Email □ Letter □ Mobile Phone □ Landline □

Patient Signature_____