NEW PATIENT REGISTRATION FORM

NAME:……..DOB:……..

CURRENT WEIGHT_____ CURRENT HEIGHT_____

ALLERGIES
Do you have allergies or are you sensitive to drugs or dressings: YES/NO
Details_____

FAMILY HISTORY – Do you have any relevant family history eg: Diabetes? YES/NO
Details_____

SOCIAL HISTORY
Do you smoke YES/NO Never - Ceased smoking date:_____

Alcohol YES/NO If yes how many standard drinks per week?_____

Drug Use_____(Type and frequency)

PAST MEDICAL HISTORY
OPERATIONS?_____

Hypertension (Blood Pressure) YES/NO - Diabetes approx. date diagnosed_____

Asthma: approx. date diagnosed_____ Other/s_____

OVER 65 YEARS: When was the last time you were immunized?
Influenza Date_____ Unsure/Never
Pneumcoccal pneumonia Date:_____Unsure/Never

FEMALES ONLY: When did you last have:
Pap Smear/CST Date:_____ Unsure/Never
Breast Check: Date:_____ Unsure/Never

MEN ONLY: When did you last have?
An overall check up Date:_____Unsure/Never

CHILDRENS IMMUNISATIONS: - If completing this form for a child is their immunization up to date?
YES/NO UNSURE
CURRENT MEDICATIONS:_____
_____

Your privacy is very important to us. It is the policy of this practice to maintain security of personal health information at all times and to ensure that this information is only available to authorized members of staff. The information collected in this form will be kept confidential at all times. All staff employed at this clinic are bound by a confidentiality agreement in accordance with accreditation standards. A copy of our privacy policy is available at the front desk.
STAFF USE ONLY: Initials:_____Date:_____