Dr Campbell & Partners — Patient Registration Form

YOUR DETAILS

Surname	☐Mr ☐Mrs ☐Miss ☐Ms ☐Dr ☐Other
First name	
Middle Name(s)	
Any previous surnames?	
Date of birth:	(DD/MM/YYYY)
What is your marital status?	☐ Single ☐ Married ☐ Living with partner ☐ Separated ☐ Divorced ☐ Widowed
Home address	
	Post Code:
Telephone number – home	
- work	
- mobile	

INFORMATION REGARDING YOUR HEALTH

Have you any allergies or reaction to drugs	☐ **Yes** ☐ **No**					
Height						
Weight						
Do you smoke	☐ Yes ☐ No *If yes how many a day*					
Have you ever smoked	☐ Yes ☐ No *If yes when did you stop*					
How much do you drink a week	Beer		Wine		Spirits	
How often do you take regular exercise of 20 minutes or more	(number of times a week)					
When is your next smear due						
In which country were you born?						
What is your ethnic origin?	***White***…….. ☐ White British ☐ White Irish ☐ Other white ***Asian / Asian British***… ☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Other Asian ***Black / Black British***… ☐ Black Caribbean ☐ Black African ☐ Other Black ***Mixed*** ……..…. ☐ White/Asian ☐ White/Black African ☐ White/Black Caribbean ☐ Other mixed ***Other ethnic group*** …. ☐ Chinese ☐ Other ethnic group					
What is your occupation?						

Have you ever suffered from any of the following	**Yes**	**No**	***Have you ever suffered from any of the following***	**Yes**	**No**
Diabetes			Asthma		
stroke			Heart disease (MI or CVA)		
DVT			Pneumonia		
Bronchitis			Mental Health Problems		
Do you have a Family History of					
Heart Disease under 60					
Heart Disease over 60					
Diabetes					
Asthma					
Stroke under 60					
Stroke over 60					

Are you a carer? Yes/No If yes, who do you care for:

Patient Access: You can register for Emis Access to order your repeat prescriptions and book appointments. Please ask reception for an on-line registration form.

Do you want to opt out of the Summary Care Record? If Yes please ask receptionist for an Opt Out Form