

Wye Valley Surgery

Dr Carter & Partners • 2 Desborough Avenue • High Wycombe • Bucks • HP11 2RN

New Patient Registration Form

For the purpose of registration please complete this form in.

You will need to make an appointment with a Doctor/Nurse/Chronic Disease clinic if you need any regular medication or consultation for any other reason.

Name:
 Date of Birth: Male/Female (please circle)
 Address:

 Post Code: Telephone No:
 Occupation: Marital Status:
 Ethnic Origin:
 Name & Address of previous Doctor:

Have you ever had (or had treatment for) any of the following:

Please tick	Yes	No	Please tick	Yes	No
Asthma			Heart Attack		
Angina /Chest pains			Hepatitis/Jaundice		
Bronchitis			High Blood Pressure		
Back Pain/disc trouble			Kidney Trouble/Cystitis		
Bowel trouble			Nervous trouble/Breakdown		
Cancer			Pneumonia		
Convulsion/Fits			Rheumatic Fever		
Chronic cough			Rheumatism/ Arthritis		
Diabetes			Skin Rash		
Drink/Drug Problem			Stomach trouble/ Ulcer		
Eye Trouble/Glaucoma			Stroke		
Ear trouble/Deafness			Shortness of breath		
Gall Stones			Thrombosis		
Heart Trouble			Tuberculosis		
Hay Fever			Womb trouble		

Has a parent, brother or sister ever suffered from:-

Family History of	Family Member	If deceased, please state age at death
Angina		
High Blood Pressure		
Heart Attack		
Stroke		
Diabetes		
Cancer (if so what type)		

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Are you a carer to any individual who suffers from any physical or mental disability?
YES/NO (please circle).

Do you have a carer because you are physically impaired?
YES/NO (please circle).

Carer's Name & Telephone No:

If you would like information about help available for Carers please ask for a leaflet.

If you are aged under 16, please state School attended:
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Have you had any serious illness/injury/operation? YES/NO
Details and dates if appropriate?.....
.....
.....

Do you have any physical defects or disability? YES/NO
Details and dates if appropriate?.....
.....

Do you have any allergy to any medication/food or any other substances known to you?
YES/NO
Details and dates if appropriate?.....
.....

Do you smoke? YES/ NO Have you ever smoked? YES / NO How many a day:
What age did you start: When did you stop:

Do you drink Alcohol? YES /NO. How many units per week?.....

When did you have your last smear test?..... Date next due:
Result.....

List any vaccinations you have had with dates if known?

List all regular medication you take?

SIGNED: DATE:.....