Have you ever been registered with the practice before: YES / NO **(please circle)**

Surname: ____________________________

Forenames: ____________________________

Mr/Mrs/Ms/Miss ___________________

Address: ____________________________________

Date of Birth ________________________

____

Ex Forces: YES / NO **(please circle)**

Next of Kin: _________________________________

Date of Enlistment:________________

Relationship: _______________________________

Date of Discharge:_________________

Contact No: _________________________________

Personnel No:______________________

ETHNIC ORIGIN: _______________________

Do you need an interpreter / sign language support? YES/NO **(please circle)**

Marital Status: Single / Married / Separated / Divorced / Widowed / Other **(please circle)**

Occupation: ____

Who lives with you? ____

What serious illness have you had? ____

What operations have you had? ____

Do you have any medical problems? ____

Please list any allergies you have? ____

Please list any tablets, medicines or other treatments you are taking (inc. those bought from chemist):

____

____

Are there any serious diseases that affect members of your family?

____

____

Would you be interested in a new patient medical interview? _________________________________

WOMEN ONLY:	When did you last have a breast scan?	______________________
	When did you last have a cervical smear?	______________________