

# TURRET MEDICAL CENTRE

## New Patient Registration Information

Forename  Surname  DOB

Address

Post Code:

Marital status  Place of birth  Ethnic origin

Home tel  Mobile tel  Work tel

Email address:

We use various systems to communicate with you regarding your health and under the new GDPR 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 each box below to confirm you are happy for us to communicate in these ways:**

Text message:  Email:  Letter:  Mobile phone:  Landline:

### Next of kin

Forename  Surname  DOB

Address

Post Code:

Relationship:

Home tel  Mobile tel  Work tel

### Lifestyle

Height  Smoking status  Are you an ex-smoker?

Weight  If smoker, how many per day?  When did you stop?

Do you drink alcohol?  How much do you drink?  Blood pressure if known

### Social Circumstances

Occupation  Are you a carer?  Do you have a carer?

Is this a formal arrangement?

### General History

Do you have or have you suffered from any of the following?

Condition	When?	Condition	When?
Heart attack/angina	<input type="text"/>	Epilepsy	<input type="text"/>
Diabetes	<input type="text"/>	Hypothyroidism	<input type="text"/>
Asthma/COPD	<input type="text"/>	Cancer	<input type="text"/>
Stroke	<input type="text"/>	Depression	<input type="text"/>
High blood pressure	<input type="text"/>		

