



4 Edwin Hall Place  
Hither Green Lane  
London SE13 6RN

Telephone 020 8698 6664  
Out-of-hours Telephone 020 8693 9066  
Fax 020 8698 6966

## New Patient Registration Questionnaire

Please help us by filling in this questionnaire as it may take some time for your full medical records to reach us. The information you give will be used to provide you with good medical care until we receive your medical records.

### Personal Details:-

Title: _____	Home No: _____
Forenames: _____	Mobile No: _____
Surname: _____	Work No: _____
Date of Birth: _____	Occupation: _____
Next of Kin: _____	Contact No: _____

### Personal Status:-

Single: <input type="checkbox"/>	Married/ Civil Partnership <input type="checkbox"/>	Co-Habiting: <input type="checkbox"/>
Divorced: <input type="checkbox"/>	Separated: <input type="checkbox"/>	Widowed: <input type="checkbox"/>

### Information about Your Lifestyle & General Health:-

Are you a Refugee? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you an Asylum Seeker? Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you Speak English? Yes <input type="checkbox"/> No <input type="checkbox"/>	What is your first language: _____
Do you need an interpreter? Yes <input type="checkbox"/> No <input type="checkbox"/>	(please state language): _____
Do you have allergies? Yes <input type="checkbox"/> No <input type="checkbox"/>	(please state): _____
Do you smoke, if so how many a day? _____	
Do you drink, if so how much per week? _____	
Past medical history: _____	
_____	
_____	
Are you caring for or helping to care for a disabled/frail/ill partner, relative, child or friend? Yes <input type="checkbox"/> No <input type="checkbox"/>	
_____	
_____	

### General Practitioners

Dr Ngozi Uduku B.Sc. Hons. MBChB. DRCOG MRCP  
Dr Mahazu Yisa MBBS 1976 MRCP 1984



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**Accommodation Details:-**

Private Rent:  Council:  Sheltered Housing:  Hostel:   
Private Ownership:  Other:  (please state): \_\_\_\_\_

**Ethnic Group:-**

White British	<input type="checkbox"/>	White Irish	<input type="checkbox"/>	Other White	<input type="checkbox"/>
Black Carrib. & White	<input type="checkbox"/>	Black African & White	<input type="checkbox"/>	Asian & White	<input type="checkbox"/>
Other Mixed	<input type="checkbox"/>	Indian	<input type="checkbox"/>	Pakistani	<input type="checkbox"/>
Bangladeshi	<input type="checkbox"/>	Other Asian	<input type="checkbox"/>	Black Caribbean	<input type="checkbox"/>
Black African	<input type="checkbox"/>	Other Black Ethnic	<input type="checkbox"/>	Chinese	<input type="checkbox"/>

**Information about Your Family:-**

( Which of the following have your blood relations suffered from: i.e. Father, Mother, Sister, Brother or Grandparents )

Heart Attack	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Cancer	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Sickle Cell	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>
Other	<input type="checkbox"/>	_____							

**Details of Vaccinations you have had:-**

Tetanus, Polio, Flu, etc: \_\_\_\_\_  
\_\_\_\_\_

**For Female Patients Only:-**

Have you had any children? \_\_\_\_\_ Give ages: \_\_\_\_\_  
Have you had a miscarriage? \_\_\_\_\_ Give date: \_\_\_\_\_  
Have you had a hysterectomy? \_\_\_\_\_ Give date: \_\_\_\_\_  
Date and place of your last smear test? \_\_\_\_\_ Result: \_\_\_\_\_  
Which method of contraception if any, are you using at present? \_\_\_\_\_