Welcome to West Gate Medical Practice

Have you been registered at Westgate previously? Yes No

Please complete as fully as possible. Any questions can be answered at your New Patient Assessment appointment. After completion please return the form to the Receptionist and make an appointment.

Name ....

Address ....

Date of Birth .... Home Tel No ....

Email address ______________________ Mobile Tel No ______________________

Occupation ....

Are you a carer .... Do you have a carer? ....

NEXT OF KIN

Next of Kin .... Mobile /Tel No ....

Relationship to patient ....

HEALTH HISTORY

Year (if known) What major illnesses have you had?

....

....

....

Smoker – YES/NO. If "YES", how many cigarettes daily? ....

Ex-smoker – year stopped ....

Never smoked ....

What is your height? .... What is your weight? ....

FAMILY HISTORY

Are there any serious illnesses, which run in your family?

....

....

Has any member of your family developed a stroke or heart disease before the age of 60?

....

Children – Please list, giving name and year of birth

1. .... 2. ....

2. .... 4. ....

5. .... 6. ....

DRUGS AND MEDICINES

Are you taking any medicines or treatments? YES/NO. If "YES" please give details (Please bring repeat prescription slip to New Patient Assessment). If unavailable write below.

Name of medicine	How often taken
....	....
....	....
....	....

Are there any medicines of substances that you have reacted to and what was this reaction? YES/NO. If "YES" please give details below.

Name of Medicine	What was the problem or upset
....	....
....	....
....	....

FOR WOMEN

Have you had a cervical smear? YES/No. If "YES", year last done ....

OTHER INFORMATION

What is your first language : ....

Are you registered disabled – if yes please give details:

....

....

Do you hold a Living Will? (A Living Will is documentation regarding your personal wishes in respect of medical intervention at the time of serious illness).

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