MD MAYFAIR DOCTORS®

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New Patient Registration Form

All information given in this form will be strictly confidential, only to be used by your consultant. If patient is a child, form must be filled by parent or legal guardian.

Personal Details			
Title:	First name:	Surname:	
Date of birth:	Nationality:	Gender: Male ○ Female ○	
Telephone (Home/Work):		Telephone (Mobile):	
Email:		Referred By:	
Address:		*If patient is child, to be filled by parent or legal guardian:* Name: Address *(If different from child):*	
G.P Name & Address:		Would you like us to contact your G.P.? Yes ○ No ○	
Emergency Contact			
Name:		Relationship:	
Address:		Tel (Home/Work):	
		Tel (Mobile):	
Carers			
Do you have a Carer? Yes ○ No ○		Name *(if applicable)*:	
Would you like them to deal with your health affairs here? Yes ○ No ○			

How are you paying?

Credit/Debit Card ○ Company Account ○ Cash ○

How did you hear about us?

Internet ○ Word of mouth ○ Other ○

If other please specify:

Would you like us to contact you with any news or information which may be of interest to you? Yes ○ No ○
Your information will not be passed on to any 3rd parties.
If you do not wish to receive any correspondence at any time, please tick circle ○

Please specify all drugs, medicines, tablets or pills that you take regularly: _____

_____ _____

_____ _____

_____ _____

Are you allergic to any medications?_____

Continue overleaf

Personal Medical History

Answer the question by ticking the appropriate circle, if you have answered yes, please comment.

Have you ever suffered or do you suffer from	Yes	No	Comments
chronic illnesses?	○	○	
heart or chest problems?	○	○	
blood pressure problems?	○	○	
epilepsy fits, faints or blackouts?	○	○	
heart disease/ heart attack?	○	○	
diabetes?	○	○	
a stroke?	○	○	
allergies, hay fever or eczema?	○	○	Please list:
cancer or been treated for cancer before?	○	○	
blindness or Glaucoma?	○	○	
depression or psychosis?	○	○	
Do you have any disabilities?	○	○	Please list:
Have you had an operation or are there any other medical conditions the doctor should know about?	○	○	

Your Health

	Yes	No	
Do you smoke?	○	○	If yes, how many cigarettes per day:
Are you an ex smoker?	○	○	Date stopped:
Do you drink alcohol?	○	○	If yes, how many units per day:

1 unit = Half a pint of beer or 1 glass of wine or 1 measure of spirit

How many times a week do you exercise 20 minutes or more?

Family Medical History

Is there anyone in your family who has had: (please tick the correct boxes)

Heart disease/ Heart Attack	○	Asthma	○
Strokes	○	Cancer	○
Blood Pressure	○	Any Chronic Illness	○
Diabetes	○		

Women Only

	Yes	No		
Have you had a cervical smear test in the last three years?	○	○	Date:	Result:
Have you had a hysterectomy?	○	○	Date:	Result:
Do you take the contraceptive pill?	○	○	If yes, which one:	
Do you have a coil/IUD fitted?	○	○	When:	What type:
Any pregnancies?	○	○	If yes please list years:	
Any complications during pregnancies?	○	○	If yes please list:	
Are you pregnant?	○	○		

I have carefully read and understood this questionnaire and filled this form to the best of my knowledge.

I am aware that this a private health clinic, and I will be charged a consultation fee, and any additional treatments or test will incur further charges, which I will be made aware of before undertaking. If I am unsure about costs of my treatment, I will ask for clarification from a member of staff. I will pay the fees I have incurred prior to leaving the clinic. I understand there is no obligation to any treatment or tests after the initial consultation

Print Full Name: _____

Relationship (if patient is child): _____

Signed: _____ Date: _____