MOUNT FLORIDA MEDICAL CENTRE

NEW PATIENT REGISTRATION

Name: _____ **Tel No (Home):** _____
Tel No (Mobile): _____
Tel No (Work): _____

DOB: _____

Ethnicity: _____ **1st Language if not English:** _____

Interpreter needed: YES / NO

Marital Status: _____ **Children:** _____ **Occupation/School:** _____

Next of Kin (Name): _____ **Relationship:** _____ **Tel No:** _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING HEALTH PROBLEMS?

	YES/NO	DATE OF DIAGNOSIS	CODE
Asthma			.H33
Diabetes ON insulin Type 1			.C108
Diabetes ON insulin Type 2			
Diabetes NOT on insulin			.C109
Chronic renal problems			.1Z1
Epilepsy			.F25
Chronic obstructive pulmonary disease			.H3
Angina			.G33
Heart attack			.G30
High blood pressure			.G20
Depression			.EU32
Atrial Fibrillation			.G573
Heart failure			.G583
Thyroid Problems			CO4%
Peripheral Arthritis			.G734
Learning Difficulties			
Stroke/TIA			.G66
Mental Health Issues			

ANY OTHER ILLNESSES?			
ANY OPERATIONS?			

ARE YOU TAKING ANY MEDICATION ON A REGULAR BASIS? **YES / NO**
(Please include contraceptive pill if applicable)
If YES, please list it, including dose.

_____ _____ _____
_____ _____ _____
_____ _____ _____

DRUG ALLERGIES: _____

FAMILY HISTORY (IN A CLOSE BLOOD RELATIVE)

Asthma	**YES / NO**	**Heart Attack/Angina**	**YES / NO**
Diabetes	**YES / NO**	**High blood pressure**	**YES / NO**
Cancer	**YES / NO**	**Stroke**	**YES / NO**

DO YOU SMOKE? **YES / NO** **ARE YOU AN EX SMOKER?** **YES / NO**

If YES, how many per day? _____

If YES would you like support to stop smoking? YES / NO

If you are an EX SMOKER, when did you stop? _____

DO YOU DRINK ALCOHOL? YES / NO (If YES how many units per week? _____ **)**

If YES, please complete the attached Fast Alcohol screening questionnaire.

FEMALE PATIENTS ONLY (25-65 YEAR OLD)

If you have had a hysterectomy, please give approximate date. _____

Mount Florida Medical Centre offer the following text messaging services. Please indicate if you would or would not like to opt into these services.

1. Appointment reminder messages
2. Annual review reminder messages
3. Flu immunisation and vaccine messages
4. Test Result Messages
5. Prescription Reminder messages
6. Bowel Screening Reminder messages

I (NAME)……..Date of Birth…… wish / do not wish to consent to the Text Message reminder service offered by Mount Florida Medical Centre.

For Official Mount Florida Medical Centre use only
Code 9NdP for Consent Code 9NdQ for consent declined