

**Registration Form - Adult Screen**

Title: Ms/Miss/Mrs/Mr/Other \_\_\_\_\_

First Name(s): \_\_\_\_\_

Surname: \_\_\_\_\_

Date of Birth:

Address: \_\_\_\_\_

Postcode: \_\_\_\_\_

Telephone - Home: \_\_\_\_\_ Daytime: \_\_\_\_\_ Mobile: \_\_\_\_\_

Occupation: \_\_\_\_\_

**Consent**

I give permission for **Choice Healthcare Services Ltd.** to keep my personal and medical details on record, in paper and in computerised form.      yes  no

I give permission for **Choice Healthcare Services Ltd.** To contact my NHS doctor for further Medical information if considered necessary.      yes  no

I want my NHS GP to be informed of the consultation(s).      yes  no

Doctor: \_\_\_\_\_

Practice: \_\_\_\_\_

Address: \_\_\_\_\_

I understand that **Choice Healthcare Services Ltd.** is registered under the Data Protection Act 1984 and that all my personal and medical information will be treated in the strictest of confidence.

Signed: \_\_\_\_\_ Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please tell us how you hear about **Choice Healthcare Services Ltd.** (Please tick one or more boxes)

Leaflet  Recommendation  Family/Friends  Workplace  Internet   
Local Newspaper  Yellow Pages  TV  National Newspaper  Radio

**Medical questionnaire**

Title: Ms/Miss/Mrs/Mr/Other \_\_\_\_\_

First Name(s): \_\_\_\_\_

Surname: \_\_\_\_\_

Date of Birth:

Please tick yes or no box and give brief details if possible

Current Health  good  problem details \_\_\_\_\_

High Blood Pressure  yes  no details \_\_\_\_\_

Diabetes  yes  no details \_\_\_\_\_

Heart Problems  yes  no details \_\_\_\_\_

Asthma  yes  no details \_\_\_\_\_

Stroke  yes  no details \_\_\_\_\_

Arthritis Rheumatism  yes  no details \_\_\_\_\_

Anxiety/Depression  yes  no details \_\_\_\_\_

Other Illness  yes  no details \_\_\_\_\_

Operations  yes  no details \_\_\_\_\_

Medication  yes  no details \_\_\_\_\_ dose \_\_\_\_\_

Allergies  yes  no details \_\_\_\_\_

Smoking History  yes  non smoker  ex smoker  no. of cigarettes daily

Alcohol intake  nil  yes  amount in units per day  per week per month

Sexual Health  good  problem details \_\_\_\_\_

Immunisations up to date  need booster  need travel immunisation  details

Cholesterol Level (if known) \_\_\_\_\_

Family Illness  yes  no details \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Any other details \_\_\_\_\_

Signed: \_\_\_\_\_ Name: \_\_\_\_\_ Date: \_\_\_\_\_