COOTEHILL MEDICAL CENTRE

Patient registration form

Please fill in the following form in BLOCK LETTERS.

Name: _____
Surname: _____ Sex: M F
DOB: ___/___/_____ Age: _____
Address: _____
_____
_____
_____
Eircode: _____

Telephone Nr: Home _____ Mobile _____
Do you have a medical card?
Yes Medical card number _____
No

VHI or BUPA Yes No
Name of previous GP _____

Have you ever suffered from?

High Blood pressure	Yes	No
Diabetes	Yes	No
Bowel problem	Yes	No
Prostate problem	Yes	No
Kidney problem	Yes	No
Heart problem	Yes	No
High cholesterol	Yes	No
Stomach ulcer	Yes	No
Asthma	Yes	No
Cancer	Yes	No
Osteoporosis	Yes	No
Arthritis	Yes	No
Hearing problem	Yes	No
Any other medical condition not listed	Yes	No

Please fill in other side of form:

If child under 5 years, have they had all childhood vaccines?

Yes No Don't know

At present are you on any tablets, injections or herbal treatments?

Yes No

Do you have any allergies to treatment / injections / tablets?

Yes No

Do you smoke? Yes No

Signed _____

Date _____

Thank you for your co-operation