**NEW PATIENT REGISTRATION FORM**

|  |  |  |
| --- | --- | --- |
| Surname/Family name: | Forename/First names(s): | Previous Names: |

Do you live in a Care/Residential Home Are you housebound

|  |  |
| --- | --- |
| Address: | |
| Date of Birth: Town and Country of Birth:  Marital Status:  Gender: | |
| Home telephone number:  Work telephone number: | Mobile number:  If you are giving us a mobile number it will be assumed you are giving us permission for text messaging, we may contact you regarding appointments/test results/annual recalls via SMS.  Please let us know if you wish to Opt Out |
| Occupation: | |
| Are you a service veteran? Yes | |
| Who else lives in your home: | |
| Name of your next of kin: | |
| Relationship: Contact Number: | |
| Are you a carer, if yes who do you care for: | |
| Do you have a carer, if so who cares for you: | |

**Medication – Please bring your medication to your new patient medical**

|  |  |
| --- | --- |
| Medication/ Strength | Dose and Frequency e.g. 1 tablet twice per day |
| 1. |  |
| 2. |  |
| 3. |  |
| 4. |  |
| 5. |  |
| 6. |  |
| 7. |  |
| 8. |  |
| 9. |  |
| 10. |  |

**Allergies –** Are you allergic to any medicines? Do you have any other allergies, e.g. pollen, dust, cat fur? Please list.

|  |
| --- |
| 1. |
| 2. |
| 3. |

**Medical Conditions – Please tell us about any conditions for which you receive regular checks by the nurse or doctor, i.e. asthma, blood pressure, diabetes**

|  |  |
| --- | --- |
| Condition | Year Started |
| 1. |  |
| 2. |  |
| 3. |  |
| 4. |  |
| 5 |  |
| 6. |  |

**Past Medical History – Please tell us of any illnesses or operations you have had.**

|  |  |
| --- | --- |
| Illness/Operation | Year |
| 1. |  |
| 2. |  |
| 3. |  |
| 4. |  |
| 5. |  |
| 6 |  |

**Is there anything else that you think we need to be aware of?**

|  |
| --- |
|  |

**Family Health –** think about your parents, grandparents, sisters, brothers. Have any of them suffered from:

|  |  |  |  |
| --- | --- | --- | --- |
| Diabetes |  | Stroke |  |
| Heart Problems |  | Asthma |  |
| Cancer (what type) |  | High Blood Pressure |  |
| Thyroid Disorder |  | Other family illness |  |

|  |
| --- |
| How often do you exercise? – No. of times per week |
|  |
| Type(s) of exercise |

|  |
| --- |
| Your Height Your Weight |

|  |
| --- |
| Do you drink alcohol ? Yes / No |
| Overall, how many units of alcohol do you drink per week? |

**Smoking**

|  |  |
| --- | --- |
| Do you smoke? | Yes / No |
| If yes, how many daily? |  |
| Have you ever smoked? | Yes / No |
| If yes, how many did you smoke? |  |
| If you have stopped smoking, please state what year you stopped |  |
| Do you need advice on giving up smoking? | Yes / No |

|  |
| --- |
| Do you take drugs for pleasure? Yes / No |
| If so, what do you take?  How often? |

**FEMALE PATIENTS ONLY**

|  |  |
| --- | --- |
| When was your last smear done | Date: |
| Was this at your GP Surgery | Yes / No |
| What was the result of your smear? |  |
| Date of last Mammogram (if applicable) |  |
| Do you take Hormone Replacement Therapy (HRT) | Yes / No |
| Method of contraception if used |  |

**All Patients**

I would describe my ethnic origin as (please tick relevant box)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| British/Mixed British |  | White & Asian |  | Other Asian |  |
| Irish |  | Other mixed |  | Caribbean |  |
| Other white |  | Indian/British Indian |  | African |  |
| White/Black Caribbean |  | Pakistani/British Pakistani |  | Other Black |  |
| White/Black African |  | Bangladeshi/Brit Bangladeshi |  | Chinese |  |
| Do not wish to supply this info |  |  |  |  |  |

My main spoken language is

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| English |  | Urdu |  | Punjabi |  |
| Polish |  | Bengali |  | French |  |
| Gujerati |  | Hindi |  | Cantonese |  |
| German |  | Ukrainian |  | Other  Please specify |  |

**Specific Needs**

**Please detail below any specific needs you have so we can ensure they are identified and accommodated by taking the appropriate action:**

|  |
| --- |
| **Please state any Sensory Impairment you have Speech, Hearing, Sight** |
| **Do you require the help of a translator/ Interpreter?** |
| **Please state any physical disabilities you have** |
| **Any requirements you have to access the Practice premises** |

**Additional Information**

Would you be interested in joining our Patient Participation Group? If yes, please add your e-mail address

E-mail …………………………………………………………………………………..

Are you interested in ordering your prescriptions on-line? If so, please ask at Reception for further information.

**Would you like an appointment for a New Patient Check? Yes / No**

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE. IT WILL FORM A VALUABLE PART OF YOU MEDICAL RECORD AND THE INFORMATION WILL BE KEPT CONFIDENTIAL.