## PERSONAL DETAILS

|  |  |  |  |
| --- | --- | --- | --- |
| Marital Status: | | | Sex M  F |
| Surname: | | First name: | |
| Date of Birth: | | | |
|  | | | |
| **Next of Kin** | Name: | | |
| Relationship to you: | | Telephone: | |
|  | | | |
| What is your first language? | | | |
| Do you need an interpreter? Yes  No | | | |
|  | | | |
| Are you a Veteran (served in armed forces)? Yes  No | | | |
| Are you a Carer? Yes  No  If yes, for whom? | | | |
| Does someone care for you? Yes  No  If yes, who? | | | |
| Do you struggle to communicate? Yes  No  If yes, what help do you need? (e.g. hearing loop, large print, lip reading) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |

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| --- | --- | --- | --- |
| **Ethnic Group,** please tick one of the following groups: | | | |
| White: | British | Irish | |
| Black: | Caribbean | African | |
| Asian: | Indian | Pakistani | Chinese |
| Mixed: | White & Asian | White & Black Caribbean | White & Black African |
| Other (please state): | | | |

**FOR CHILDREN REGISTERING (UNDER 16s) :**

We need to match the child to the parent/guardian’s household when registering.

**Parent  Guardian  (tick relevant box)**

**SURNAME ………………………………..**

**FIRST NAME ……………………………..**

**DATE OF BIRTH …………………………**

**Please provide a copy of any immunisations your child has had.**

# FEMALE PATIENTS ONLY

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| --- | --- |
| Are you currently pregnant? | Yes  No |
| If yes, how many weeks? | weeks |
| Have you had a hysterectomy? (Give date) |  |
| When was your last smear test? |  |
| Which country was your smear taken in? |  |
| I would like a smear reminder letter sent, please tick |  |

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| We often communicate with patients via text for things such as appointment reminders and to collect important health information  I give consent to receiving text messages Yes  No  I give consent to receiving emails from the practice Yes  No  Data Sharing Opt Out Form (please read and complete enclosed leaflet) |

**YOUR HISTORY:**

Do you have any of the following chronic illnesses? *(tick all that apply)*

Diabetes  Asthma/COPD  Heart problems

Hypertension  Cancer  Epilepsy  Stroke

**FAMILY HISTORY**:

**Which of your blood relations have suffered the following:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Family member | Age |  | Family member | Age |
| Heart attack |  |  | Asthma |  |  |
| Stroke |  |  | High Blood Pressure |  |  |
| Cancer |  |  | Cardiovascular disease |  |  |
| Diabetes |  |  | Other serious illness |  |  |

# GENERAL HISTORY

Have you had any serious illnesses, X-rays or similar tests? Yes  No

If yes, what illness, x-rays or similar tests? ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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If you have had an operation, what type and when? ­­­­­­­­­­­­­­­­­­­­­­­­­­­­–

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Are you awaiting any test results? Yes  No .

If yes, where from\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please state what type of test \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you any allergies? If Yes, to what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**FOR STAFF ONLY TO COMPLETE: Staff name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_**

**Please inform patient of named GP**

**Audit C completed**  **(child) Imms data requested**

**Data sharing**

**BP checked**  **(if high apt made? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)**

**Medication slip**  **(for patients on multiple repeats)**

**ID PROVIDED: 1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PHOTOCOPIED\_\_\_\_\_\_\_\_**



**NEW PATIENT QUESTIONNAIRE**

Please complete this questionnaire and hand it to the reception staff along with your completed registration form.

**Please note that it will take up to two weeks for the documentation to be processed and for you to be registered at the practice.**

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**Weight: Height:**

**Blood pressure:** Please use machine in reception, write your name and date of birth on the back and hand slip to receptionist with this form.

**Repeat medication:** Please provide us with a copy of your current repeat medication (or boxes from pharmacy). All prescriptions are sent electronically to the pharmacy please provide your nominated pharmacy below.

Nominated Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Smoking status**: *(tick box that applies)*  Current smoker:  Ex-smoker:  Never smoked  If you currently smoke, how many cigarettes do you smoke per day? \_\_\_\_\_\_  Do you use an e-cigarette/vaporiser? Yes  No  For some years now the evidence has shown that smoking is not good for people’s health. **If you smoke** and would like help in giving up, please visit [www.nhs.uk](http://www.nhs.uk) and search for Quit Smoking. They provide advice and ideas on medication to assist in becoming smoke free. |