## PERSONAL DETAILS

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| --- | --- |
| 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 informationI 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- |
| **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.  |