



NEW PATIENT REGISTRATION QUESTIONNAIRE - ADULT

To register with the Practice please complete this questionnaire as fully as possible before your new patient assessment and also bring in **two forms of identification** one with a photo either passport or driving licence and one to verify your address. These must all be original documents and not copies. This has to be done prior to being registered.

Date __/__/__

TitleSurname: Forename(s):

Date of Birth: Age in years:Place of birth:.....Marital status:

Address:

..... Postcode:

Home tel:

Mobile:Tick box to signify happy to receive text messages such as reminders:

Email address:

Previous GP/surgery.....and reason for changing:

.....

Occupation:.....

Next of Kin & contact details and relationship to you:.....

What Language is spoken at home?

What is your Religion?

Ethnicity – please tick appropriate box (one box only)

British or British Mixed Irish Other White Background White and Black Caribbean

White and Black African White and Asian Other Mixed Background Indian or British Indian

Pakistani or British Pakistani Bangladeshi or British Bangladeshi Other Asian background

Caribbean African Other Black Background Chinese

Ethnic category not stated Any other Ethnic Group

CARERS

Are you a carer ? If so please who do you care for ?

Do you have a carer ? Name of your carer and contact telephone no.....
(Carer support packs may be obtained from reception)

SMOKING

Do you smoke? Yes / Not Any Longer /Never

If Yes, how many: Cigarettes per day Cigars per day Ounces of tobacco per day

If you are an ex-smoker: When did you stopped smoking?

How much did you smoke per day?

ALCOHOL – Please ring the correct answer and answer all 3 questions below.

(1 unit of Alcohol = half pint of beer, 1 glass of wine or a pub measure of spirits)

QUESTIONS					
<i>How often do you have a drink containing alcohol?</i>	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
<i>How many units of alcohol do you have on a typical day when you are drinking?</i>	1 or 2	3 or 4	5 or 6	7 or 8	10 or more
<i>How often have had 6 or more units if female or 8 or more if male on a single occasion in the last year?</i>	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

Weight (approx): **Height:**

EXERCISE

Do you take regular exercise? Yes / No

If yes, what sort of exercise? How many times per week?

PAST/PRESENT MEDICAL CONDITIONS

Please give details (& dates) of any medical conditions you have including Heart Disease, Diabetes, Kidney Disease, Stroke or Dementia.

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.....

MEDICATION

Please give details of any medication which you take (prescribed or otherwise):
Please bring your repeat request form or the containers to your first appt

Name of drugs & Dosage:

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.....
.....

PHARMACY NOMINATION...(Please nominate a pharmacy where you wish to collect your prescriptions).....

DIET

Do you have a varied diet including milk, meat, vegetables and fruit? Yes / No

ALLERGIES

Are you allergic to any substances or foods? Yes / No

If yes, please give details:

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IMMUNISATIONS

Please give details immunisations & dates – including holiday jabs:

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FEMALE PATIENTS

Date of most recent cervical smear:

Have you been advised that your next one needs to be repeated earlier than usual ?.....

Please give details of any pregnancies:

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FAMILY HISTORY

Is there any of the following in your close family (*father, mother, brother, sister*) before age of 65?
Heart Disease (heart attacks, angina) / Stroke / Insulin dependant diabetes / Glaucoma or Cancer (specify site) or any other known hereditary disease ?

Condition(s) and family member(s) affected?

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Have you any medical problems that you would like to discuss with the doctor or nurse
(this may mean you require a double appointment for your new patient assessment appointment):

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COMMUNICATION

Do you have any special communication needs? (for example hearing, sight or memory problems)

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Thank you for completing this questionnaire. Your doctor will assess the information provided and will invite you for an initial examination, discussion about your health, and general check within 2 days of receipt of completed details.

Office use:

- Scope 1 Patients not registered elsewhere and new to area. Register and book assessment appointment.
- Scope 2 Registered with another Practice (in or out of WP area) or doubtful reasons for change. Complete questionnaire then refer to Partner/PM. Will book appointment within 48 hours or provide details if refused.
- Scope 3 If foreign, i.e. non-British citizenship or if in doubt, we must obtain original documents (passport with residency stamp, UK Identity Card for Foreign Nationals/Residence Permit, not birth certificate on its own) with rights to health benefits clearly set out. If unable to provide evidence the applicant will be refused. EC citizens should be able to produce an EC or EEA identity card.

For further guidance refer Protocol 125 New Patient Registration Policy

Passed to Partner or PM: Who:..... Date:.....

Accepted or refused: Reason for refusal:

Refusal letter sent by:..... Date:.....

Accepted and registered: Date:..... by:.....(staff member)

Health check appointment date: