

# Practice Name

## New Patient Registration Form (Adult: 16 and over)

Today's Date

### Instructions for completing this form

1. Complete a separate form for each family member to be registered
2. Complete in BLOCK CAPITALS and tick the boxes as appropriate

<b>1</b>	<b>Full Name:</b>				<b>Date of Birth:</b>	
	<b>Title :</b> <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms				<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other. <i>Please state :</i>	
	Other. <i>Please state :</i>				<b>Marital Status:</b>	
	<b>Mobile tel. number:</b>  We will use this to send appointment reminders and health promotion details. Please tick here to give your consent for this: <input type="checkbox"/>				<b>Maiden name / Mothers name if different:</b>	
	<b>Work tel. number:</b>				<b>E-mail address:</b>	
	<b>Next of Kin:</b> <b>Relationship to Patient:</b>				<b>Next of Kin contact tel. number:</b>	
	<b>How would you prefer us to contact you:</b> <input type="checkbox"/> Letter <input type="checkbox"/> Email <input type="checkbox"/> SMS (text) <input type="checkbox"/> Phone					
	<b>Town* and Country of birth</b>		<b>Country:</b>		<b>Borough (*If born in London):</b>	
	(*If town is London please state which Borough)		<b>Town:</b>			
	<b>Please list other residents of your home who are registered with us:</b>		<b>Name:</b>		<b>Date of Birth:</b>	

<b>2</b>	<b>Looking After A Family Member</b>		
	<b>Are you looking after someone?</b> Let us know if you are looking after someone who is ill, frail, disabled or has mental health and/or emotional support needs, or substance misuse problems.		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<b>Is someone looking after you?</b> Let us know if a family member, friend or neighbour looks after you. If yes, they are your carer. You are welcome to invite your carer to accompany you to visits at the practice.		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<b>Carer's name :</b>		<b>Relationship to you:</b>
	<b>Address of carer :</b>		
<b>Telephone number of carer :</b>			

<b>3</b>	<b>Are You Currently Employed?</b>				
	If so please specify whether :		<input type="checkbox"/> Full-time	<input type="checkbox"/> Part-time	<input type="checkbox"/> Self-employed
	If you are not employed, please indicate which best describes you:				
	<input type="checkbox"/> Retired	<input type="checkbox"/> Student	<input type="checkbox"/> Housewife/ Homemaker/House husband		<input type="checkbox"/> Unemployed
	<input type="checkbox"/> Other <i>Please state:</i>				
If returning from the Armed Forces please state which below:				<b>Comments:</b>	
<input type="checkbox"/> Army <input type="checkbox"/> Royal Navy <input type="checkbox"/> Royal Air force					

<b>4</b>	<b>Your Religion</b> (please state):			
	It's important to let us know if your religion will affect any treatment you receive			
	<b>Your Ethnic Origin</b> (Please tick one)			
	<input type="checkbox"/> Black Caribbean/British	<input type="checkbox"/> Indian / British Indian	<input type="checkbox"/> Arabic	<input type="checkbox"/> White (UK)
	<input type="checkbox"/> Black African /British	<input type="checkbox"/> Pakistani / British Pakistani	<input type="checkbox"/> Chinese	<input type="checkbox"/> White (Irish)
	<input type="checkbox"/> Other Black Background	<input type="checkbox"/> Bangladeshi / British Bangladeshi	<input type="checkbox"/> Other	<input type="checkbox"/> White (Other)
	<input type="checkbox"/> Other Mixed Background	<input type="checkbox"/> Other Asian Background		<input type="checkbox"/> Ethnic Category Refused
	<b>Do you need an Interpreter?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, which language:</b>			
	<b>Do you need help with mobility/hearing/speaking?</b> (tick all that apply)			
	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Walking aid	<input type="checkbox"/> Hearing aid	<input type="checkbox"/> British sign language (BSL)
<input type="checkbox"/> Lip reading	<input type="checkbox"/> Large print	<input type="checkbox"/> Braille	<input type="checkbox"/> Other, Please state:	
<b>Are you currently?</b>	<input type="checkbox"/> Homeless	<input type="checkbox"/> A Refugee	<input type="checkbox"/> An Asylum Seeker	
<b>Are you an 'Assistance Dog' User?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Are you housebound?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No		

<b>5</b>	<b>Lifestyle</b>							
	<b>Are you currently a smoker?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Have you ever been a smoker?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		If you smoke, how many Cigarettes / Cigars / Tobacco do you smoke in a day?					
	If you are a smoker and want to STOP please tick here: <input type="checkbox"/>							
	<b>Alcohol:</b>		<b>Scoring System</b>				<b>Your Score</b>	
			0	1	2	3		4
	How often do you have a drink containing alcohol?		Never	Monthly Or Less	2-4 Times Per Month	2-3 Times Per Week	4+ Times Per Week	
	How many units* of alcohol do you drink on a typical day when you are drinking?		1-2	3-4	5-6	7-9	10+	
How often have you had 6 or more units if female, or 8+ if male, on a single occasion in the last year?		Never	Less Than Monthly	Monthly	Weekly	Daily Or Almost Daily		
<i>*Alcohol Units: 1 Pint Of Premium Beer = 2.5 Units.            1 Pint Beer/Cider = 2 Units. Single Measure Of Spirit = 1 Unit. Small (125ml) Glass Of Wine = 1 Unit</i>						<b>Total Score</b>		

6	<b>Diet and Exercise</b>		<b>What type of diet do you have?</b>	
	<b>How much exercise do you do?</b>		<input type="checkbox"/> Healthy	
	<input type="checkbox"/> Sedentary (No exercise)		<input type="checkbox"/> Unhealthy	
	<input type="checkbox"/> Gentle (climbs stairs, walking , gardening)		<input type="checkbox"/> Vegan	
	<input type="checkbox"/> Moderate (Cycling, swimming regularly)		<input type="checkbox"/> Vegetarian	
	<input type="checkbox"/> Vigorous (Attends gym regularly)		<input type="checkbox"/> Moderate	
	<b>Please enter your height in</b>		<b>Please enter your weight in</b>	
Feet / inches:	cm:	Kilos/grams:	Stones / lbs:	

7	<b>Women Only</b>	What is the date of your last <b>Smear test</b> ?	Date:	Result:
	Was this at your GP Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last <b>Mammogram</b> (if applicable):	
	Number of <b>pregnancies</b> (include miscarriages & terminations) (If applicable)			
	Do you wish to see a doctor in this Practice for contraceptive services (including the pill, coil or cap)?			
				<input type="checkbox"/> Yes <input type="checkbox"/> No

8	<b>Your Medical Background</b>				
	Are there any serious diseases that affect your parents, brothers or sisters? Tick all that apply <u>and</u> state family member:				
	<input type="checkbox"/> <b>Diabetes</b> Who:	<input type="checkbox"/> <b>Asthma</b> Who:	<input type="checkbox"/> <b>Thyroid disorder</b> Who:	<input type="checkbox"/> <b>Stroke</b> Who:	<input type="checkbox"/> <b>COPD</b> Who:
	<input type="checkbox"/> <b>Heart Attack under age of 60</b> Who:	<input type="checkbox"/> <b>Cancer (Specify type)</b> Who:	<input type="checkbox"/> <b>High Blood pressure</b> Who:	<input type="checkbox"/> <b>Any other important family illness. <u>Please state:</u></b> Who:	
	Please state any allergies and sensitivities you have to medicines, food & dressings:				
	Please state any mental disabilities you have:				
	Are you able to administer your own medicines?	<input type="checkbox"/> Yes <input type="checkbox"/> No		<b><u>If no</u></b> please give details, e.g. swallowing or opening containers:	
	What long term medical conditions have you had?				Date of Diagnosis:
	What operations or serious injuries have you had?				Date of operations or injuries:
	Please list any tablets, medicines or other treatments you are currently taking / undertaking:				
	We can now send your prescriptions electronically to the pharmacy of your choice. If you would like us to do this, please give the name and location of the pharmacy here:				

