

**NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE –**

Once your registration is complete, your previous medical records may take several weeks to arrive to us so please complete this questionnaire below as fully as possible.

You are required to bring in 2 forms of identification (one with a photo, i.e., passport, driving licence and one to prove your address i.e., a recent utility or credit card bill from within the last 3 months) in order to enable you to register as a patient here and to register for patient online access.

**Mr/Mrs/Miss/Ms**

**Surname:** …………………………………………..….……. **Forename(s)** ……………………………………………………………….

**Date of Birth:** …………………………………………… **Marital/Partnership status:** .………………………………………….

**Address:** ….…………………………………………………………………………………………………………………………………………

………………………………………………………………………………..………………………………………………………………………….

**Postcode:** .......................…………..…… **Town & Country of Birth:** …………………………………………………………

**Home Telephone:** …………………………………………...…….. **Mobile:** ……………………………………………………………

**Email address:** …………………………………………………………………………..……………………………………………………....

**Next of Kin:** …………………………………………………………….. **Relationship to you:** ……………………………………….

**Next of Kin Contact Number:** ……………………………………………………………………………………………………………..

**Occupation:** ……………………………………. **Are you or have you ever been in the Armed Forces?:** YES/NO

**Weight (approx.):** …………………………………………….. **Height:** ……………………………………..……………………………

**NHS Number:** ………………………………………………………… **Religion:** ……………………………………………………….....

**Employment Status:** ………………………………………….. **Date of completion of form:** ………………………………

**Is this the first time you have registered with a GP in the UK? -** YES/NO

**Previous GP Surgery Name and Address: ………..**…………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………………….

Please indicate below your ethnic origin and gender identity. These questions are not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins and gender identity may help with the early identification of some of these conditions.

**ETHNIC ORIGIN –** (Please tick from the following list)

[ ] British or Mixed British

[ ] Irish

[ ] Other White Background

[ ] Indian or British Indian

[ ] Pakistani or British Pakistani

[ ] Bangladeshi or British Bangladeshi

[ ] Caribbean

[ ] African

[ ] Other Black Background

[ ] White and Black Caribbean

[ ] White and Black African

[ ] White and Asian

[ ] Other Mixed Background

[ ] Other Asian Background

[ ] Chinese

[ ] Other: ……………………………………….

**First language:** ……………………………………………………………………………………………………………………………………

**If your first language is not English, do you require an Interpreter?** .………………………………………………..

**GENDER IDENTITY AND TRANS STATUS MONITORING –**

**Which of the following best describes how you think of yourself?**

**Woman (including trans woman)** [ ]  **Man (including trans man)** [ ]  **Non-binary** [ ]

**In another way (please state):** …………………………………………………………………………………………………………..

**Is your gender identity the same as the gender you were given at birth**? **Yes** [ ]  **No** [ ]

**ACCESSIBILITY –**

**Do you have a disability?** YES/NO

**If yes, please specify** …………………………………………………………………………………………………………………………..

**Do you have any information or communication needs?** YES/NO

**If yes, please specify** ………………………………….……………………………………………………………………………………….

…………………………………………………………………………………………………………………………………………………………….

**SMOKING AND ALCOHOL STATUS –**

**Do you smoke? YES/NO**

**What year did you start smoking?** ……………………………  **Would you like to stop smoking?** YES/NO

**How many cigarettes would you smoke on a typical day?**

|  |
| --- |
| 0-5 |[ ]
| 5-10 |[ ]
| 10-15 |[ ]
| 15-20 |[ ]
| 20+ |[ ]

**Ex-Smokers - How old were you when you stopped smoking?** …..…………………………………….……………….

**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 on a single occasion in the last year?**

|  |
| --- |
| Never |[ ]
| Less than monthly |[ ]
| Monthly |[ ]
| Weekly |[ ]
| Daily or almost daily |[ ]

**EXERCISE –**

**Do you exercise regularly?** (Please tick one option)

|  |
| --- |
| Exercise Physically Impossible |[ ]
| Avoid even trivial exercise |[ ]
| Enjoy light exercise |[ ]
| Enjoy moderate exercise |[ ]
| Enjoy heavy exercise |[ ]

**FAMILY HISTORY –**

**Is there any of the following in your family?** (Please tick any that apply)

|  |  |  |
| --- | --- | --- |
| **MEDICAL CONDITION** | **YOURSELF** | **FAMILY MEMBER** |
| Asthma |[ ] [ ]
| Bronchitis/emphysema |[ ] [ ]
| Cancer  |[ ] [ ]
| Diabetes |[ ] [ ]
| Depression |[ ] [ ]
| Epilepsy |[ ] [ ]
| Heart Disease |[ ] [ ]
| High Cholesterol |[ ] [ ]
| Hypertension |[ ] [ ]
| Stroke |[ ] [ ]

**Please give details of any treatment for any long-term medical conditions: ..........................**………….

…………………………………………………………………………………………………………………………………………………………….

**ALLERGIES –**

**Are you allergic to any substances or foods? –** YES/NO

**If Yes, please give details:** ..…………………………………………………………………………………………………………………

**Are you using any contraception?** YES/NO **If YES, what?** ..........................................................

**Date of most recent cervical smear:** …………………………………………………………………………………………………..

**Your prescription will be sent electronically to a pharmacy. Please provide the name and address of the pharmacy of your choice:**

**The Pharmacy I nominate is** ........……………………………………………………………………………………………………..

**CARERS**

**Do you need / have anyone who looks after you or your daily needs as Carer?** YES/NO

**If Yes, would you like them to deal with your health affairs here?** YES/NO

**Please provide their name and contact details** …………………………………………………………………………….……

…………………………………………………………………………………………………………………………………………………………….

**Do you care for anyone else?** YES/NO

**If Yes, please ask the receptionist about Carers support.**

**ONLINE SERVICES –**

**We can now offer patients the ability to:**

• Cancel or check appointments online

• Request repeat prescriptions

• View test results

If you have provided your email address, we will issue your unique username and password via email on completion of your registration and production of your identification documents. Alternatively, if no email address is provided please call into the surgery in 7 working days to collect this document.

**TEXT MESSAGING AND EMAIL COMMUNICATIONS –**

Our free text message service continues to prove very popular with patients. It has quickly become the preferred method of communication for many patients who receive appointment confirmations and reminders as well as health promotion information and also provides the ability to cancel an unwanted appointment. Please sign the consent below to receive communications via text and/or email.

Name: …………………………………………………………………………………………………………………………………………………

Signature: ……………………………………………………………...... Date: ……………………………………………………………..

**SUMMARY CARE RECORD –**

Care professionals in England use an electronic record called the Summary Care Record (SCR). This can provide those involved in your care with faster secure access to key information from your GP record. You can choose to share or not to share your full electronic record with other NHS care services where you are treated. If you choose to make your record shareable, your clinical details will only be viewable by clinical teams who are treating you. Each clinical team which cares for you now or in the future will ask your permission to view your shared record. All record accesses are recorded and auditable. If you require further information, you can download it here: [www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Documents/2016/SCR-patient-leaflet.pdf](http://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Documents/2016/SCR-patient-leaflet.pdf)

If you would prefer your clinical information to be withheld from the Summary Care Record (not recommended as NHS health care staff caring for you may not be aware of your current medications, allergies and bad reactions you may have had to any medicines), please sign below:

I want my clinical information to be withheld from the Summary Care Record:

Signature: …………………………………………………………………………… Date: …………………………………………………

**ORGAN DONATION –**

Please note that the law has changed to an opt out system and you will need to opt out if you do not want to become a donor. It is important to talk to your family about your organ donation decision, as they will be asked to support your decision. If you are undecided or do not want to become an organ donor, please refer to the NHS Organ Donation website at www.organdonation.nhs.uk or 0300 303 2094.

**FOR OFFICE USE –**

**2 forms of ID for the person seen**:

**1st ID** ……………………………………………………………………………………………………………………………………………….

**2nd ID** ……………………………………………………………………………………………………………………………………………….

**Name of member of staff who has seen ID**: ……………………………………………………………………………………….

**Date:** ………………………………………………………………………………………………..…………………………………………………