**THE HEALTHCARE CENTRE**

**New Patient Registration Form**

It can sometimes take several weeks for your medical records to reach us from your previous GP therefore your answers to these questions will help the Doctor. Any information that you provide will be handled confidentially.

**Have you been registered with us before? Yes No (please circle)**

**Surname: First name:**

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**Date of birth: NHS number:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name & address of previous GP:**

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**­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­Home address:**

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**Telephone no:**  **Mobile telephone no:**

\_\_\_\_\_\_\_\_\_

**Name Of Next of Kin:**  **Address & Telephone no:**

**Relationship:**

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**Ethnic Origin**

Please tick as appropriate:

|  |  |  |
| --- | --- | --- |
| **White** British/Mixed British Irish Other (please state): Other European origin (please state):**Black or Black British** Caribbean African Other black background (please state): | **Mixed** White & Black Caribbean White & Black African White & Asian Other (please state):**Chinese or other Ethnic Group** Chinese Other (please state): | **Asian or Asian British** Indian Pakistani Bangladeshi Other Asian background (please state) |
| **Main language spoken:** |

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Smoking History:**

Never smoked tobacco

Ex-smoker

Current smoker How many per day?

**If you are interested in stopping smoking:**

You can contact the NHS quit squad on 08003286297 or 01772 644474

Alternatively, you can book an appointment with the Healthcare Assistant at the Practice for help in smoking cessation.

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**Do you drink alcohol?** Yes No (Please circle)

If yes, please complete attached alcohol form

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**Do you have any known allergies?** Yes No (Please circle)

If yes, please specify:

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**Please record your height & weight below**

Height\_\_\_\_\_\_\_\_\_\_\_\_ M \_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Kg

**Do you exercise?** Yes No (Please circle)

If Yes, how much? Gentle/Moderate/Vigorous

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**Do you follow a special diet?** Yes No (Please circle)

If Yes, what type of diet? Diabetic/ Low fat/ High fibre/ Low salt

**Do you have a family history of any of the following?** (please state relationship to you eg. father)

Heart Disease (please state age of the onset of the disease)

Stroke Diabetes

Asthma Raised blood pressure

Cancer (please state what type of cancer)

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**Are you a carer?** Yes No (Please circle)

If **YES**, please state name for whom you are a carer & your relationship to them - Example: Mother, daughter, other:

As a carer you are entitled to support, an annual health check and an annual flu vaccination – please ask our reception team for more details.

**Are You Cared For? Yes No (Please circle)**

If **YES**, please state the name of whom you are cared for by & your relationship to them - Example: Mother, daughter, other etc:

**Do you have any dependants?** Yes No (Please circle) **How many? ­­­­­\_\_\_\_\_\_\_\_\_\_**

**Name of Dependants:**

**Address / Addresses of Dependants:**

**Will they be registering at the practice with you?** Yes No (Please circle)

**If No – which GP Surgery are they registered with?**

**Are you a War Veteran?** Yes No (Please circle)

**Are you a vulnerable person?** Yes No (Please circle)

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**On-line Access**

**Would you like to register for on-line access** to your medical record which will enable you to book and cancel appointments, order any repeat prescriptions that you may have and view your medical record on-line.

Yes No (Please circle)

Once we have processed your registration if you have indicated above that you require on-line access then we will post registration documentation to you detailing information required to register for this service.

Medical Conditions

**Please list any current medical conditions that you may have eg. Diabetes, Asthma**

**Date of last Cervical Smear (if applicable)**

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Medications

**If you are currently prescribed repeat medications from your previous GP please supply the right hand side of your previous prescription or the boxes of the medications for the practice to take the details from.**

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**Patient Consent for Email and Text Message Communication**

The practice wishes to expand its methods of communicating with patients to include the use of email and text messaging.

Patient Privacy is important to us, and Dr C M Wilson & Partners would like to communicate with

you regarding any activities that may be of interest, which means that we need your consent.

This may include using emails to provide updates on new developments at the practice, and the use of text messaging and emails to send patients reminders about the details of their next appointment.

*Emails and text messages are generated using a secure facility, but because they are transmitted over a public network, they may not be secure. Email and text communication will never be used for urgent communications. Your contact details will be used solely in relation to healthcare services offered by the practice, and you can choose to opt out of the services at any time by contacting the Reception team*

Please ensure you sign this form
if you consent to any, or all, of the above.

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Name |  | Date of Birth | ………./………./………. |
| Mobile |  | Consent to use? | Y | N |
| Email |  | Consent to use? | Y | N |
| Signature |  | Date |  |
|  |  |  |  |

**Please indicate your preferred method of communication:**

**Email Text Phone**

|  |  |
| --- | --- |
|  | **FOR OFFICE USE ONLY** |
| Proof of Identity | Passport Driving Licence Identity Card Other |
| Proof of Address | Utility bill Bank Statement Tenancy Agreement Other |

**Alcohol Questionnaire (AUDIT C 38D4)**

Please complete by ticking relevant answer

**Q1** How often do you have a drink that contains alcohol?

* Never (0 points)
* Monthly or less (1 point)
* Two to four times a month (2 points)
* Two to three times per week (3 points)
* Four or more times per week (4 points)

**Q2** How many standard alcoholic drinks do you have on a typical day when you are drinking?

* 1 or 2 (0 points)
* 3 or 4 (1 point)
* 5 or 6 (2 points)
* 7 to 9 (3 points)
* 10 or more (4 points)

**Q3** How often do you have 6 or more standard drinks on one occasion?

* Never (0 points)
* Less than monthly (1 point)
* Monthly (2 points)
* Weekly (3 points)
* Daily or almost daily (4 points)

**Total Score: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If total score is 5 or higher, please complete more detailed questionnaire overleaf.**

**Alcohol Questionnaire (COMPLETE AUDIT 38D3)**

**Q4** How often in the last year have you found you were not able to stop drinking once you had started?

* Never (0 points)
* Less than monthly (1 point)
* Monthly (2 points)
* Weekly (3 points)
* Daily or almost daily (4 points)

**Q5** How often in the last year have you failed to do what was expected of

you because of drinking?

* Never (0 points)
* Less than monthly (1 point)
* Monthly (2 points)
* Weekly (3 points)
* Daily or almost daily (4 points)

**Q6** How often in the last year have you needed an alcoholic drink in the morning to get you going?

* Never (0 points)
* Less than monthly (1 point)
* Monthly (2 points)
* Weekly (3 points)
* Daily or almost daily (4 points)

**Q7** How often in the last year have you had a feeling of guilt or regret after drinking?

* Never (0 points)
* Less than monthly (1 point)
* Monthly (2 points)
* Weekly (3 points)
* Daily or almost daily (4 points)

**Q8** How often in the last year have you not been able to remember what happened when drinking the night before?

* Never (0 points)
* Less than monthly (1 point)
* Monthly (2 points)
* Weekly (3 points)
* Daily or almost daily (4 points)

**Q9** How often in the last year have you or someone else been injured as a result of your drinking?

* No (0 points)
* Yes but not in the last year (2 points)
* Yes during the last year (4 points)

**Q10** Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?

* No (0 points)
* Yes but not in the last year (2 points)
* Yes during the last year (4 points)

 **Scoring System**

 **Total Score: \_\_\_\_\_\_\_\_\_**O. collaborative study