New Patient Registration Form

Please complete this questionnaire as fully as possible – your answers will help with your healthcare until your medical records arrive. We will not be able to register patients until this form has been fully completed

1. Contact details

Surname	
First names	
Date of Birth	
Address	
Telephone	Home: Mobile:
Email address	
Occupation	
I consent to be contacted by email	Yes/No
Who else could we contact in an emergency?	Name Relationship Contact Details
Occupation	

First Language (state):

Ethnic Origin- please tick (NB these categories are provided by UK government, not chosen by us)

Asian/ British Asian		**Black/Black British**		**British/mixed British**	
Indian		Caribbean		Irish	
Pakistani				Other White	
Bangladeshi		African		White & Black Caribbean	
Chinese		Any other Black background		White & Black African	
Other Asian		Other ethnic category (state)		White & Asian	
Ethnic category not stated				Other mixed background	

Please circle Yes or No answers:

2. PAST MEDICAL HISTORY

Do you have any of the following?

If so, you will be offered an annual assessment/Medication review as appropriate

High Blood Pressure	Yes	No
Diabetes	Yes	No
Asthma	Yes	No
Chronic Obstructive Airways disease (COPD)	Yes	No
Heart Disease	Yes	No

3. FAMILY HISTORY

Does any member of your family suffer from:

Please give details of any illnesses which run in your family, or affect your immediate family (parents, brothers, sisters or your children).

Disease/illness	Which relative(s) affected
High Blood Pressure	
Diabetes	
Asthma	
Chronic Obstructive Airways Disease (COPD)	
Heart Disease (under the age of 60)	
Cancer	
Stroke	
Mental Illness	

4. LADIES ONLY

When was your last Cervical Smear Test?	
Was your last smear normal?	**Yes/No**

5. GENERAL HEALTH

Do you have any allergies? (in particular to any medicine).	**Yes (please specify)**	**No**
Do you take any Regular Medication **Please provide a list of medication from your previous surgery or please ask you previous surgery to fax us your medication list**	**Yes**	**No**

Lifestyle		**If YES please provide details**
Do you smoke	Yes/No	___ cigarettes/day, or ___ g tobacco/wk
Did you smoke in the past?	Yes/No	Date quit:
Would you like help to stop?	Yes/no	
Do you use any "street" or illegal drugs?	Yes/No	
Do you keep to a special diet?	Yes/No	
Do you do regular exercise	Yes/No	
What is you weight?		
What is your height?		

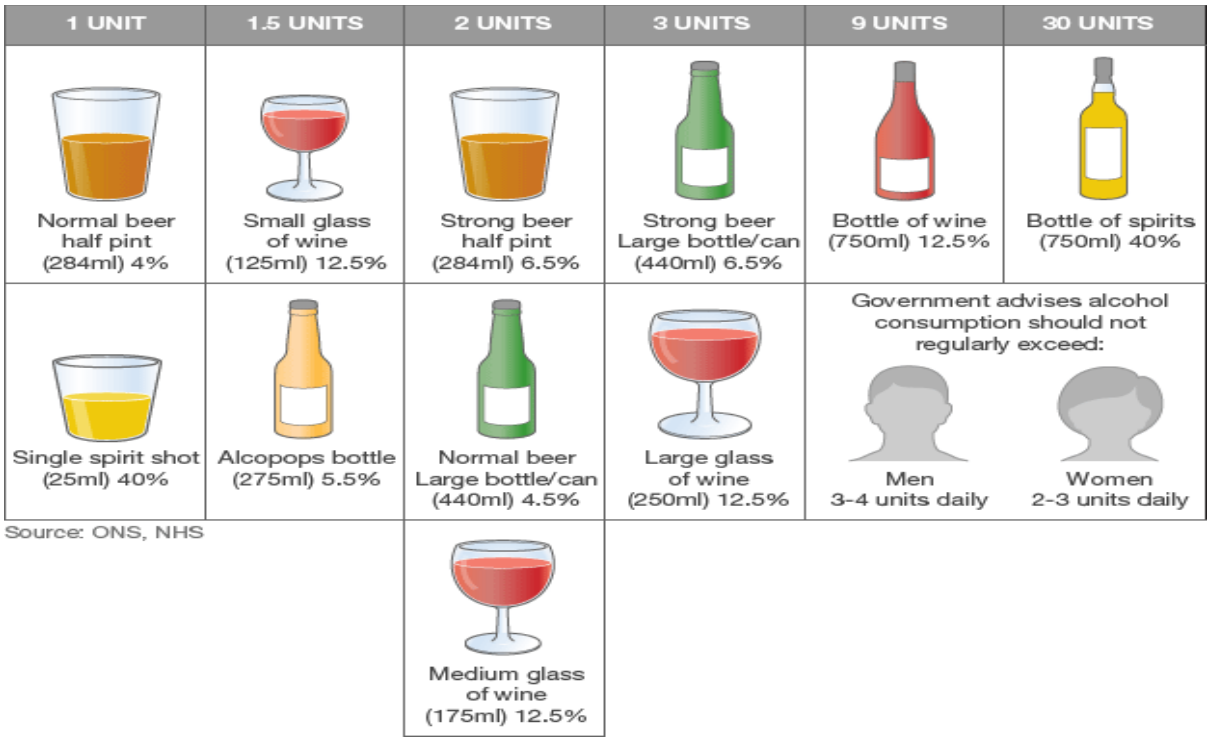
6. Alcohol User's Test

Do you drink alcohol? Yes/No

If yes, how often do you drink alcohol?

- **Never**
- **Monthly or less**
- **2 – 4 times per month**
- **2-3 times a week**
- **4+ a week**
-

How many units of alcohol do you drink per week on average?
(Please see chart below) ..... Units



Source: ONS, NHS

7. CARERS

Do you look after somebody who is frail or ill?	Yes	**No**
Does Someone look after you?	**Yes**	**No**
If Yes, please provide name/contact details		

***Do you need a new patient check appointment?**

☐ **Aged under 40, fit and well?** – No appointment needed, (We aim to process you registration within 48 hours, you will then be able to access our services)

☐ **Aged under 40, with a long term condition** eg diabetes, asthma, depression or taking 5 or more regular medications? – Yes an appointment will be offered at reception with a HCA or nurse

☐ **Aged over 40, fit and well? -** No appointment needed but please ask reception for a NHS health check blood test

☐ **Aged over 40, with a long term condition** eg diabetes, asthma, depression or taking 5 or more regular medications ? - Yes an appointment will be offered at reception with a HCA or nurse

(we will contact you with more information once registration is complete)

***SEXUAL HEALTH SCREENING**

Finally, we offer sexual health screening to everyone who registers with the practice. This includes a blood test for HIV, Hepatitis B and C and syphilis, plus a swab (female) or urine test (male) to detect chlamydia and gonorrhoea.

Yes please, I would like the above tests ☐ No thanks, I am not interested at this moment ☐

(We will contact you with more information once registration is complete)

Signature of patient_____ Signature on behalf of patient_____ **Date** ___/___/___

Thank you for completing this form

For more information about the services we offer, please refer to your new patient pack or see our website: CityWellbeingPractice.nhs.uk

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Staff use only
Date form handed in: **Checked by:**
ST I Booked Yes/No **NHS Health Check Booked Yes/No** **Smear due appointment booked Yes/No**