COLWALL SURGERY

NEW PATIENT REGISTRATION INFORMATION

To the Patient:
To register with the Practice please complete this questionnaire as fully as possible. The information will help the doctor to make an initial assessment of your health which will help in your future treatment.

Surname: …….. Previous Surname(s) if applicable:…….

Forename(s): ……..

Date of Birth: …… Marital status: ….…….. Sex: ……..

Address:……

…… Postcode:…….

Home Tel:…… Mobile:……

Email address:…….

What is your Ethnicity? …… What is your first language? …….

Country of Birth:…… Place of Birth:…….....

Occupation:……..

Your Previous Address:…….

……Postcode:……..

Date of registration…….

Name of Next of Kin and relationship to you:……..

Address of Next of Kin:……

……Contact Telephone Number:……..

Do you give permission for the surgery to disclose information to your Next of Kin? **Yes** / **No**

If Yes, please ask at reception for a consent form which you will need to sign (you will also need to discuss this with one of our GPs).

Do you have a "Living Will" (a statement explaining what medical treatment you would not want in the future)?

Yes / **No**

If **Yes,** can you please let the surgery have a copy for your medical record.

Have you nominated someone to speak on your behalf (e.g. a person who has "Power of Attorney")

Yes / **No**

Do you have any specific needs e.g. are you blind, do you need a translator? **Yes** / **No**

If **Yes**, please specify: …….

COLWALL SURGERY

Previous GP Details

Previous GP's Name and Address:……

……..

Carers

Are you a Carer, do you look after someone at home? Yes / No

Does someone care for you? Yes / No

If yes, are they registered with this practice? Yes / No

Do you give permission for the surgery to disclose information to your Carer? Yes / No

If **Yes**, please ask at reception for a consent form which you will need to sign (you will also need to discuss this with one of our GPs).

YOUR HEALTH QUESTIONNAIRE

What is your Weight : …… Height: ……

SMOKING

Do you smoke? Yes / No If **Yes**, how many: Cigarettes per day ……..

Cigars per day ..……. . . . . Ounces of tobacco per day ……..

Have you ever smoked? Yes / No If **Yes**, when did you stop smoking?.....

How many Cigarettes / Cigars did you smoke per day?.....

PASSIVE SMOKING

Are you exposed to smoke at work? Yes / No At home? Yes / No

DIET

Do you add salt to your food after cooking? Yes / No

Has your Cholesterol been checked in the last 2 years? Yes / No

EXERCISE

Do you take regular exercise? Yes / No

If yes, what sort of exercise?……

How many times per week? ……

Do you suffer from any of the following?

Stroke:……... Diabetes:……..

High Blood Pressure:……. Asthma:……..

Other – Please specify:……..

COLWALL SURGERY

ALCOHOL

How many units of alcohol do you drink per week? …….
(1 unit = half pint of beer, 1 small glass of wine, or a pub measure of spirits)

How often do you have a drink containing alcohol? (please tick)

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

How many units of alcohol do you have on a typical day when you are drinking?

- 1 or 2 (0)
- 3 or 4 (1)
- 5 or 6 (2)
- 7 to 9 (3)
- 10 or more (4)

How often have you had six or more units if female, or eight units if male, on a single occasion in the past year?

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

FAMILY HISTORY

Have any of your blood relations suffered from the following and if so who:

Stroke:……. Heart Attack:…….

Diabetes:……. Asthma:…….

High Blood Pressure:…… TB:…….

Other serious operations or illnesses:…….

MEDICATION

Please give details of any repeat medication which you are currently prescribed:

Name of Drug	Dosage

ALLERGIES

Are you allergic to medicines or anything else? Yes / No

If yes, please give details:……..

……..

COLWALL SURGERY

FEMALE PATIENTS

Have you had any children? Yes / No If yes give ages:…….

Have you had a miscarriage? Yes / No If yes please give date:……..

Have you had a termination of pregnancy? If yes please give date:……..

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

Have you had a hysterectomy? Yes / No If yes please give date:……...

Patient Access

1. Would you like to be able to order repeat prescriptions by using the internet: Yes / No

If **Yes**, please ask at reception for a registration form

2. Can we contact you by text messaging using your mobile phone number? Yes / No

Signed Patient: _____ Date: _____

For Office Use Only:

	Date:
Date of Registration	
New Patient GMS1 code on EMIS	
Alcohol Score part 1 – if over 5 need to complete part 2 at New Patient Health Check Please code on EMIS – **9k17** & score (in text)	
Registered on the System?	Yes / No
Patient Access Form for prescriptions given	Yes / No / Not required
Patient consents to text messaging If yes, Read code on EMIS **9NdP**	Yes / No / Not required
Carer status registered on the system?	Yes / No / Not required
Recorded in the 'ON' Book	
Notes received	
Notes summarised	