GP USE: DATE REG …………………….

CHECKLIST

**Please provide one form of PHOTOGRAPHIC ID ………………………Seen by- Initial of staff member…….**

**And details of PROOF OF ADDRESS …………………………………… Seen by - Initial of staff member…….**

NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE

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. Patients on repeat medication will need to attend the practice for an initial consultation before any prescriptions can be issued.

**Have you ever been registered with the surgery before YES / NO?**

**Surname: …….…………………………… First Name: …….……………………………**

**Middle Name: ………………………………. Date of Birth: …….……………………………**

**Marital status: …….……………………………**

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

**Postcode: .……………………..….**

**Home Tel: ……………………………………………..…… Mobile:** …………………………….…

**Are there other patients of this surgery living at this address? YES/ NO**

Do you consent to receiving SMS text messages for communication from the Surgery?

(incl appointment reminders) YES / NO

Do you consent to receiving emails for communication from the Surgery?

(incl appointment reminders) YES / NO

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

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

Next of Kin: …….…………………………… Relationship ……………………………………

Tel No: …….……………………………

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

……………………………………………………………….… Postcode: .……………………..….

**CARERS**

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

Relationship of carer………………………………………………………………..

Do you care for anyone else? YES / NO

Relationship to carer?......................................................................................

**SMOKING**

Do you smoke? YES / NO

If Yes, how many: Cigarettes per day …….. Cigars per day ..….. Ounces of tobacco per day ……

**EX-SMOKERS**

When did you stop smoking? …………………

How much did you smoke per day? …………………………………..

**ALCOHOL**

Do you drink Alcohol? YES / NO

Please answer the Audit-C questions below

**This is one unit of alcohol…**

****

**…and each of these is more than one unit**

****

**AUDIT – C**

|  |  |  |
| --- | --- | --- |
| **Questions** | **Scoring system** | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink containing alcohol? | Never | Monthlyor 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 |  |

**Scoring:**

**SCORE**

A total of 5+ indicates increasing or higher risk drinking.

An overall total score of 5 or above is AUDIT-C positive.

**EXERCISE**

Do you take regular exercise YES / NO

How many times per week? ………………………………………………….

How many minutes do you exercise at a time? ………………………………………………….

**FAMILY HISTORY**

**ARE YOU ADOPTED? …………….YES/NO**

Is there any of the following in your family *(father, mother, brother, sister)* before age of 65?

Heart Disease (heart attacks, angina) Yes / No Which family member? ………………………….

Stroke? Yes / No Which family member? ………………………….

Cancer? Yes / No Which family member? ………………………….

 Site of cancer? ………………………………………………

Epilepsy Yes / No Which family member? ………………………….

Diabetes Yes / No Which family member? ………………………….

Asthma Yes / No Which family member? ………………………….

Thyroid Problem Yes / No Which family member? ………………………….

**ALLERGIES**

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

If yes, please give details: ……………………………………………………………………………………………………………………

**FEMALE PATIENTS**

Date of most recent cervical smear and result…………………………………………………………

**PAST MEDICAL HISTORY**

Do you have or have you ever had any of the following?

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | Date Diagnosed | Are you still on medication or still having treatment? |
| Heart Disease | Yes / No |  | Yes / No |
| Stroke | Yes / No |  | Yes / No |
| Asthma | Yes / No |  | Yes / No |
| High Blood Pressure | Yes / No |  | Yes / No |
| Epilepsy | Yes / No |  | Yes / No |
| Mental Illness | Yes / No |  | Yes / No |
| Cancer | Yes / No |  | Yes / No |
| Thyroid Problems | Yes / No |  | Yes / No |
| Diabetes | Yes / No |  | Yes / No |
| Any other illness | Yes / No |  | Yes / No |
| *Please give details* |  |  |

**Please give details of any operations:**

|  |  |
| --- | --- |
| Operation and date  | Operation and date |
|  |  |

Do you wish to have a **New Patient Medical or NHS Health Check** (for patients aged

between 40-74)? YES / NO

*Please allow 7 days for your registration to be processed, and then contact reception to book an appointment with a Health Care Assistant.*

**ONLINE SERVICES**

We now offer online services to enable you to order repeat prescriptions, book routine appointments with the GP and view your medical summary (this will show medications, current medical problems and allergies).

To register for online access please visit <https://www.nhs.uk/using-the-nhs/nhs-services/the-nhs-app/>

The NHS App is a new, simple and secure way to access a range of NHS services on your smartphone or tablet.

Use the NHS App to:

|  |  |
| --- | --- |
| * check your symptoms
 | * view your GP medical record securely
 |
| * find out what to do when you need help urgently
 | * register to be an organ donor
 |
| * book and manage appointments at your GP surgery
 | * choose how the NHS uses your data
 |
| * order repeat prescriptions
 |  |

**ELECTRONIC PRESCRIPTIONS**

Do you have a nominated/specific pharmacy that you would like us to send your

prescriptions to? YES / NO

If yes, please give the name and address of the pharmacy …………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

**PATIENTS FROM OUTSIDE OF THE UK REGISTERING WITH A GP FOR THE FIRST TIME**

Have you completed the Supplementary Questions on the Purple GMS1 Registration

form? YES / NO

***Patient Declaration:***

I confirm the information provided on this form is correct and agree to the Practice sharing necessary information with other health professionals involved in my care, such as hospital consultants, pharmacists and therapists.

Signed……………………………………………………… Date…………………………………

**PATIENT ETHNIC ORGIN QUESTIONNAIRE**

This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act.

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

Choose ONE section from A to E and then tick ONE box to indicate your background. Then please complete your first language section at the bottom of this form.

NAME ………………………………………………………………………

DATE OF BIRTH ………………………………………………………………………

White

|  |  |
| --- | --- |
|  | British |
|  | Irish |
|  | Any other white background please write below |

Mixed

|  |  |
| --- | --- |
|  | White and Black Caribbean |
|  | White and Black African |
|  | White and Asian |
|  | Any other mixed background please write below |

Asian or Asian British

|  |  |
| --- | --- |
|  | Indian |
|  | Pakistani |
|  | Bangladeshi |
|  | Any other Asian background please write below |

Black or Black British

|  |  |
| --- | --- |
|  | Caribbean |
|  | African |
|  | Any other Asian background please write below |

Chinese or other ethnic group

|  |  |
| --- | --- |
|  | Chinese |
|  | Any other please write below |

Do you require an interpreter YES / NO

First Language ………………..……………………………………………………….

THANK YOU