The Practice of Health Registration Questionnaire

Title		**Surname**	
Date of Birth		**Forenames**	
Occupation		**Previous Surname**	
Home Address		**Telephone No:**	
		Mobile No (Age 16+):	
		Gender:	**Male / Female / Other**
		Marital Status:	
Postcode		**Email:**	

NHS Number (*if known)* :

Ethnicity (Please tick one of the following)

White	Bangladesh	Black Caribbean	Black African	Chinese
Black, other, non-mixed origin		Black, other mixed	Gypsey or Irish Traveller	
indian	Pakistani	Other ethnic mixed	Arab	Other ethnic non mixed
Other Asian	Other Black	Other ethnic mixed	Ethnicity Refused	
Welsh	English	Scottish	Northern Irish	British Irish

Language Preference: English / Welsh / Other please State:

ACCESS REQUIREMENTS

If you have any access requirements e,g, Communication, hearing, blind, any physical disability etc, please state:

What support do you require e.g. Interpreter:

CARER: If you are or have a Carer, please request a Carers Identification Form at the desk

Do you need/have anyone who looks after you or your daily needs as a Carer? Yes / No

If Yes, would you like them to deal with your health affairs here? Yes / No (*A member of reception staff can help with the arrangements)*

Do you care for anyone else? Yes/No (*If Yes, please ask reception satff about Cares Support)*

CONSENT

Do you consent to the practice contacting you by text message for appointment reminders, invitation to health checks, vaccination reminders, to let you know that your prescription/sick note is ready for collection and anything else relevent to your healthcare? **Yes/No (please delete as appropriate)**

We have an elecctronic method of contact available for patients to contact the surgery for non urgent requests - do you consent for us to correspond with you via this method and supply us with a preferred e-mail address for this purpose? **Yes/No (please delete as appropriate)**

ARMED FORCES

Have you ever served in the armed forces?

If Yes, which force and dates served:

Do you Smoke? Yes/No Cigarettes per day: ___ Ounces of Taboacco per day:___

Do you drink alcohol? Yes/No **How many units per week**? _____

750mls Bottle of Wine = 10 units. 175ml Glass of wine = 2 units.

70cl bottle of spirit = 28 units. A Single 25ml shot of spirit = 1 unit.

A Pint of 3.6% lager/beer/cider = 2 units. A Pint of 5.2% lager/beer/cider = 3 units

What exercise do you take weekly:

HEIGHT **WEIGHT**

MEDICAL & FAMILY HISTORY

The following information you supply may assist us to provide good care whilst we wait for your previous medical records

Have you ever suffered from any of the following?

HEART DISEASE: YES/NO If yes, please give more details e.g. heart attacks, angina etc

HIGH BLOOD PRESSURE: YES/NO When was your last blood presure checked?

EPILEPSY YES/NO If yes, when was your last attack?

ASTHMA YES/NO If yes, when was your last attack?

ANY OTHER SERIOUS ILLNESS YES/NO If yes, give details

OPERATIONS YES/NO If yes, what and when?

MINOR RECURRING HEALTH PROBLEMS YES/NO

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

Heart Disease? Yes/No Which family Member?**.....**

Stroke? Yes/No which family member? **.....**

Cancer? Yes/No which family member?.....

Site of Cancer? .....

ANY KNOWN ALLERGIES?

CURRENT MEDICATION TAKEN *(Please provide an up to date computer printout of your Medication from your current Practice)*

ARE YOU UP TO DATE WITH TETANUS, POLIO ETC

Blood Transfusions: Have you received a blood transfusion prior to 1996?
Yes/No *(please delete as appropriate)*

IF YOU ARE **FEMALE** PLEASE ANSWER THIS SECTION:

CONTRACEPTION: If you are using any, which tye?

When did you have a smear examination? _____

Have you had a hysterectomy? YES/NO

Are you awaiting an out-patient appointnent with a Hospital?
If Yes, which hospital and which Department?

HOSPTIAL _____ **DEPARTMENT** _____

Are you awaiting an in-patient Procedure? Yes/No
If Yes, which hospitla and which procedure?

HOSPITAL _____ **PROCEDURE** _____

If you are awaiting an appointment in a Local Hospital and you intend to continue treatment there - **You Must inform them of your change of address.**

If you have come from out of area and do not wish to travel to the Hospital at which you were to receive treatment, please make an appointment to see the doctor to discuss transferring your your referral to a local hospital.

Thank you for completing this information, we look forward to seeing you at your New Patient Health Check appointment ***(please bring a urine sample to the appointment)***

SIGNED **DATE**