# New Patient Registration and Health Questionnaire

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| **Title: (Mr, Mrs, etc.)** |  | **Date of birth** |  |
| **Forename(s)** |  |
| **Surname** |  | **Previous surname** |  |
| **Calling name** |  | **Occupation** |  |
| **Current address** |  |
| **Home phone number** |  | **Mobile phone number** |  |
| **Email address** |  |
| **NHS number** |  |
| **Previous address** |  |
| **Previous GP** |  |
| **Have you been registered here previously? If yes, please give dates.** |  |
| **Have you moved to the UK from abroad? If yes, give date of arrival in the UK.** |  |
| **Next of kin details:****Title:****Surname:****Forename:****Relationship:****Address:****Telephone numbers:** |  |
| **Armed Forces veterans’****service:****Dates of service:****Discharge date:****Address prior to serving:** |  |
| **Special circumstances:** | Please tick if any of the following apply:I have a carer I am a carerAsylum seekerHouseboundLive in a nursing homeLive in a residential homeLive in a community psychiatric homeLive in a children’s home |
| **Height** |  | **Weight** |  |
| **Allergies** |  | **Disabilities** |  |
| **Are you:****Registered blind or partially sighted****Registered deaf****Registered disabled** | Please state which of these apply: |
| **Please state your ethnicity** |  |
| **Do you have any drug allergies?*****Please include known reactions*** |  |
| **Do you have any other allergies?*****Please give as much detail as possible*** |  |
| **Do you suffer from any of the following:****Heart disease****Hypertension****Asthma****Diabetes****COPD****Chronic kidney disease****Epilepsy****Stroke****Cancer** | Please state which of these apply and give date of last review: |
| **Do you have any other serious or chronic illness?** | Please explain: |
| **Do you have a family history of:****Diabetes****Heart disease****High cholesterol****Heart attack****Stroke****Cancer**  | Please give details including relationship, illness and age at diagnosis if known: |
| **Have you had any significant injuries or major operations?** | If yes, please give details: |
| **Smoking status – Are you:****A current smoker****An ex-smoker****A non-smoker** | If a current or ex-smoker, please give details of how many you smoke or smoked per day. If you are an ex-smoker please give the date you stopped (month / year). |
| **Smoking cessation advice is available. Would you like further information?** | If yes, please ask at reception or see our website for details. |
| **How many units of alcohol do you drink on a typical day when you are drinking? (1 unit = ½ a pint or a small glass of wine or a single pub measure of spirits)** | Please tick which applies:1-23-45-67-910+ |
| **How often have you drunk more than 8 units (men) or 6 units (women) on a single occasion in the past year?** | Please tick which applies:NeverDailyWeeklyMonthlyLess often than monthly |

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| **Alcohol scoring system** | 0 | 1 | 2 | 3 | 4 | Score |
| **How often do you drink alcohol** | Never | Monthly or 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 drinking?** | 1-2 | 3-4 | 5-6 | 7-9 | 10+ |  |
| **How often have you drunk more than 8 units (men) or 6 units (women) on a single occasion in the past year?** | Never | Less often than monthly | Monthly | Weekly | Daily or almost daily |  |

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| **Advice is available if you would like to reduce your alcohol intake.** | Please ask at reception or see our website for details. |
| **Current medication** | If possible, attach a copy of your repeat prescription list. |
| **Medication** | Dosage | Repeat | Quantity remaining |
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| **Females only:** |
| **Date of last cervical smear** |  |
| **Contraception used** |  |
| **Over 65s:** |
| **Have you had a pneumonia vaccine in the last 10 years?** |  |
| **Have you had a flu vaccine this year?** |  |
| Please use this space to give any other information you feel is appropriate: |
| **PATIENT DECLARATION** |
| **I confirm that, to the best of my knowledge, the information I have provided is accurate and correct.** |
| **Signature** |  |
| **Print name** |  |
| **Date** |  |

Thank you for completing this form.

Please return this form to a member of the reception team who will make an appointment for your new patient health check.