

NEW PATIENT REGISTRATION QUESTIONNAIRE 15 YEARS AND OVER

DATE:

COMPULSORY INFORMATION REQUIRED
COMPLETE BOTH SIDES OF FORM PLEASE

Registration cannot be accepted without all information completed.

GENERAL

SURNAME:	FORENAME:
Date of Birth:	Title:
Address:	Postcode:
Tel:	

Next of Kin:	
Tel / contact details:	

LIFESTYLE (AGED 15+)

Do you smoke? YES/NEVER/EX SMOKER	Would you like advice to help stop smoking?	YES (give leaflet or make appt) NO
---	--	---

Coded:

IDENTIFICATION RECEIVED WITH PROOF OF ADDRESS *(ie phone bill/utility bill)*
code as ..EMISNQPA44 (patient address validated)

Any serious illness or hospital admissions in last few years? :

DATE	MAJOR DISEASES	PROBLEM

DRUG ALLERGIES *Please state any known drug allergies:*

OTHER ALLERGIES *Please state any known allergies;*

REPEAT MEDICATION/ONGOING MEDICAL ISSUES YES/NO

- If YES please contact the surgery to arrange a New Patient Health Check with the GP
- If NO please contact the surgery to arrange a New Patient Health Check with the Health Care Assistant.

P.T.O.

MEDICAL HISTORY

DIABETES	YES/NO *
ASTHMA	YES/NO *
COPD	YES/NO *
EPILEPSY	YES/NO *
STROKE	YES/NO *
HIGH BLOOD PRESSURE	YES/NO *
HEART DISEASE	YES/NO *
SPLENECTOMY	YES/NO *

What is your Ethnic Group? Please tick the appropriate box to indicate your cultural background.

<u>White</u>		<u>Asian/Asian British</u>		<u>Black/Black British</u>	
Scottish <input type="checkbox"/>	English <input type="checkbox"/>	Indian <input type="checkbox"/>		Caribbean <input type="checkbox"/>	
Irish <input type="checkbox"/>	Welsh <input type="checkbox"/>	Pakistani <input type="checkbox"/>		African <input type="checkbox"/>	
<u>Mixed</u>		Bangladeshi <input type="checkbox"/>			
White/Black Caribbean <input type="checkbox"/>		<u>Chinese/other ethnic group</u>			
White/Black African <input type="checkbox"/>		Chinese <input type="checkbox"/>			
White/Asian <input type="checkbox"/>					

Any other please write in

FEMALES...only

Have you ever had a cervical smear test? YES/NO	If yes date of test:
Where was it done?	GP <input type="checkbox"/> Clinic/Hospital <input type="checkbox"/>
In which country?	UK <input type="checkbox"/> Abroad <input type="checkbox"/>
What was the result?	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
Do you currently have a coil (IUCD)	YES/NO
Do you currently have an implant (Implanon)	YES/NO

TO BE COMPLETED FOR PATIENTS AGED 15 +

DATE:	BMI:
HEIGHT:	B.P.
WEIGHT:	

CARERS

A carer is an individual irrespective of age, who provide or supervise a substantial amount of care on a regular basis of a child, relative, partner or neighbour who is unable to manage on their own due to illness, disability, frailty, mental distress or impairment.

Are you a carer **YES/NO**

COMMENTS

.....

CHECKLIST

Coded on Computer