**NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE**

**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. On completion of this form you will be given an appointment to attend the practice for an initial consultation and some basic health checks with a member of staff from our nursing team. All information supplied is confidential.

You are required to bring in 2 forms of Identification (one with a photo, ie; passport, driving licence and one to prove your address ie; a utility or credit card bill) in order to enable you to register as a patient here and to register for patient online access.

Surname: ……………………………………….………………….. Forename(s): ………………………………………………………………

Date of Birth: …………………………………………………….. Marital/Partnership status: ..……………………………………..

Address: ……………………………………………………………………………………………………………………………………………………

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

Is this a care home?.......................................................................................................................................

Home tel: …………………………………………..…………..…… Mobile: ………………………………….…………………………….…..

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

***Please ensure you provide your email address so you can be registered for Patient Online Access.***

Occupation: …………………………………………………………………… Armed Forces Veteran: Y / N (please circle)

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

NHS Number: ………………………………………………………… Religion:………………………………………………………………….

Employment Status: …………………………………………….. Date of completion of form …………………………………..

Please indicate below your ethnic origin, sexual orientation and gender identity. These questions are not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins and gender identity may help with the early identification of some of these conditions.

**Ethnic Origin**

A British or Mixed British

B Irish

C Other White Background

D Indian or British Indian

E Pakistani or British Pakistani

F Bangladeshi or British Bangladeshi

G Caribbean

H African

I Other Black Background

J White and Black Caribbean

K White and Black African

L White and Asian

M Other Mixed Background

N Other Asian Background

O Chinese

P Other

Q Information Refused

First language: …………………………………………………………………………………………………………………………………………

If your first language is not English, do you require an Interpreter? ………………………………………………………..

**Sexual Orientation, Gender Identity and Trans Status Monitoring**

Which of the following best describes how you think of yourself?

Straight or Heterosexual ☐ Gay or Lesbian ☐ Bisexual ☐ In another way
 (please state): ………………………

**Which of the following best describes how you think of yourself?**

Woman (including trans woman) ☐ Man (including trans man) ☐ Non-binary ☐

In another way (please state): …………………………………………………………….

**Is your gender identity the same as the gender you were given at birth?**

Yes ☐ No ☐

**Accessibility**

Do you have a disability Yes/No

If yes, please specify ………………………………………………………………………………………………………………………………

Do you have any information or communication needs Yes / No (please circle)

If yes, please specify ………………………………………………………………………………………………………………………………..

………………………………………………………………………………………………………………………………………………………………….

**Smoking**

Do you smoke? Yes / No

What year did you start smoking? ………………… Would you like to stop smoking? Y/N (Please circle)

How many cigarettes would you smoke on a typical day?

|  |  |
| --- | --- |
| 0-5 |  |
| 5-10 |  |
| 10-15 |  |
| 15-20 |  |
| 20+ |  |

**Ex-Smokers**

How old were you when you stopped smoking? …………….

**Alcohol**

How often do you have a drink containing 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 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 |  |

**Diet**

How is your diet? Do you have a varied diet? (Please tick one option)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Diet Good |  | Diet Average |  | Diet Poor |  |

**Exercise**

Do you exercise regularly? (Please tick one option)

|  |  |
| --- | --- |
| Exercise Physically Impossible |  |
| Avoid even trivial exercise |  |
| Enjoy light exercise |  |
| Enjoy moderate exercise |  |
| Enjoy heavy exercise |  |

**Family History**

Is there any of the following in your family? (Please tick any that apply)

|  |  |
| --- | --- |
| Ischaemic Heart Disease |  |
| Stroke |  |
| Diabetes |  |
| Cancer |  |
| Asthma |  |
| Hypertension |  |

**Medication**

Please give details of any medication which you take (prescribed or otherwise)

|  |  |
| --- | --- |
| **Name of Drug** | **Dosage** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Your prescription can be sent electronically to a pharmacy of your choice. If you would like to register for this service, please provide the name and address of the pharmacy of your choice:**

The Pharmacy I nominate is ...........………………………………………………………………………………………………………..

**Allergies**

Are you allergic to any substances or foods? Yes / No (please circle)

If Yes, please give details:

…………………………….……………………………………………………………………………………………………………………………………

**Past Medical History**

Please give details of any hospital treatment as an in-patient:

…………………………….……………………………………………………………………………………………………………………………………

Please give details of any treatment for any long term medical conditions:

…………………………….……………………………………………………………………………………………………………………………………

Please give dates of any X-ray/MRI or CT scans/mammogram/ultrasound.:

…………………………….……………………………………………………………………………………………………………………………………

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

Please give details of any complications in pregnancy:

…………………………….……………………………………………………………………………………………………………………………………

**Carers**

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

If Yes, would you like them to deal with your health affairs here? Yes / No

Please provide their name and contact details: …………………………………………………………………………………….…

………………………………………………………………………………………………………………………………………………………………….

Do you care for anyone else? Yes / No

If Yes, please ask the receptionist about Carers support

**Online Services**

**We can now offer patients the ability to:**

* Book, cancel or check appointments online
* Update address details and phone numbers
* Request repeat prescriptions
* Give feedback about the practice

**If you have provided your email address, we will issue your unique username and password via email on completion of your registration and production of your identification documents. Alternatively, if no email address is provided please call into the surgery in 7 working days to collect this document from the upstairs reception between 9-5pm.**

**Text Messaging and Email Communications**

Our free text message service continues to prove very popular with patients. It has quickly become the preferred method of communication for many patients who receive appointment confirmations and reminders as well as health promotion information and also provides the ability to cancel an unwanted appointment. Please sign the consent below to receive communications via text and/or email.

Name ……………………………………………………………………………

Signature ……………………………………………………………………... Date …………………………………………………………….

**Summary Care Record**

Care professionals in England use an electronic record called the Summary Care Record (SCR). This can provide those involved in your care with faster secure access to key information from your GP record. You can choose to share or not to share your full electronic record with other NHS care services where you are treated. If you choose to make your record shareable, your clinical details will only be viewable by clinical teams who are treating you. Each clinical team which cares for you now or in the future will ask your permission to view your shared record. All record accesses are recorded and auditable. If you require further information, you can download it here: [www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Documents/2016/SCR-patient-leaflet.pdf](http://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Documents/2016/SCR-patient-leaflet.pdf)

If you would prefer your clinical information to be withheld from the Summary Care Record **(not recommended as NHS health care staff caring for you may not be aware of your current medications, allergies and bad reactions you may have had to any medicines),** please sign below:

I want my clinical information to be withheld from the Summary Care Record:

Signature ……………………………………………………………………………………… Date ………………………………………………

**Organ Donation**

Please note that the law has changed to an opt out system and you will need to opt out if you do not want to become a donor.  It is important to talk to your family about your organ donation decision, as they will be asked to support your decision. If you are undecided or do not want to become an organ donor, please refer to the NHS Organ Donation website at [www.organdonation.nhs.uk](http://www.organdonation.nhs.uk/) or 0300 303 2094.

Thank you – please now take the completed form to Reception or email it to us at trccg.firsway.enquiries@nhs.net

**For office use:**

*2 forms of ID for the person seen*

*1st ID ……………………………………………………………………………………………………………….*

*2nd ID ……………………………………………………………………………………………………………….*

*Name of member of staff who has seen ID ………………………………………………………………………………………………..*

*Date …………………………………………………………………………………………………………..………………………………………………*