NEW PATIENT REGISTRATION

Complete a registration questionnaire for **EACH** new patient over the age of 5. We ask that you complete all sections carefully and give as much information as possible. Your application to register may be delayed if they are returned incomplete.

For all children under the age of five, please complete the separate form.

Surname:	
Fore Name:	
Mr / Mrs / Miss / Ms / other:	
Date of birth:	
Male / female:	
Address and postcode:	
Telephone: **Home:** **Work:** **Mobile:** **(please ensure you contact us if your number changes)**	
Email address:	
Are you are Carer? (if so, please give details)	
Name of playschool / nursery / school or college (where applicable)	

Please be aware that by entering your email address / mobile phone number you are giving the surgery permission to contact you by this method

LAST SURGERY

Name and place of last surgery: _____

Please provide a reason for leaving your last surgery:

Reason	Please add further information below
Moved away?	
Last surgery inconvenient to use?	
To be with family registered here (please name)?	
Problems in last surgery?	
Other?	

If you had a complaint against your last surgery or there were other problems, please describe.

ETHNIC GROUP

Please tick which group you belong to:

Black (African)		Chinese		Other European	
Black (Asian)		Greek / Greek Cypriot		Turkish / Turkish Cypriot	
Black (British)		Indian		White	
Black (Caribbean)		Indian sub continent		Other (please state)	
Black (Indian sub continent)		Irish			

We record ethnic groups as some groups are more susceptible to some medical problems than others.

NEXT OF KIN

If you are very ill, we may need to contact your next of kin. Who is your next of kin? _____
Contact telephone number: _____ How long would it take them to get to you? _____

Please sign below for permission to contact the above should it become necessary:

Signed: _____

MEDICATION

Please list any repeat medication that you are currently taking:

Drug	Strength and dosage information

ALLERGIES

Please state if you suffer from any allergies either:

1. Drugs e.g. Penicillin	Yes		No	
2. Contact e.g. dermatitis, eczema	Yes		No	
3. Seasonal e.g. hay fever	Yes		No	

(If you take medication for hay fever, please ask to have your medication put on a repeat prescription. This will often save you from needing an appointment with your GP in order to get a prescription.)

Please supply a very **brief history of any medical problems**, so that we have some record (in the event of you having to be seen by a doctor) before your notes arrive at the surgery. Please list any conditions that took you into hospital, any operations, and any important or continuing conditions.

MARITAL STATUS

Please tick which section applies to you:

Single		Married		Divorced	
Widowed		Separated		Co-habiting	

OCCUPATION

Please state your occupation (please state if you are a student): _____

HEIGHT AND WEIGHT

Height:	Weight:

LONG STANDING CONDITIONS

Do you suffer from any of the following (please provide extra information where appropriate)?

1. High blood pressure, hypertension?	Yes		No	
2. Coronary heart disease, heart attacks, left ventricular function?	Yes		No	
3. Have you had any operations to treat your heart problems (please state)?	Yes		No	
4. Stroke or transient ischemic attacks?	Yes		No	
5. Asthma?	Yes		No	
6. Chronic Obstructive Pulmonary Disease (COPD)?	Yes		No	
7. Diabetes?	Yes		No	
8. Epilepsy?	Yes		No	
9. Hypothyroidism (please state if you suffer from any other thyroid problems)?	Yes		No	
10. Cancer (not including non – melanotic skin cancers)?	Yes		No	
11. Mental Health (long term problems)?	Yes		No	

12. Glaucoma, cataract or other eye problems?	Yes		No	
13. Taking Vitamin B12 injections?	Yes		No	
14. Taking the medication “Amiodarone”?	Yes		No	
15. Taking “Zoladex” or “Prostap” or any other regular specialised injection (not insulin)?	Yes		No	
16. Renal problems (has a transplant or are asplenetic?	Yes		No	

FAMILY HISTORY
For all of the above conditions, please give details of any immediate family member (siblings, parents) who has suffered from the condition:

VACCINATIONS
If you travelled abroad in the past 10 years or less and needed vaccinations, please provide details of the vaccinations you received and approximate dates (if you have a travel vaccination card, please bring this with you to your “new patient check”)

When was the last time you had a Tetanus injection? _____

All patients aged below 24 should have received a vaccination for Meningitis (c strain). Have you received this vaccination (whether at your previous doctors’ school or university)? _____

Have you had your BCG? (if so please give approximate date)? _____

What date did you have your “school leavers” (Diphtheria, Tetanus and Polio) vaccination?
_____

EXAMINATIONS
Do you regularly (with self examination) check either your breast or testicles? Yes ☐ No ☐

CONTRACEPTION
Are you currently pregnant? Yes ☐ No ☐ If yes how many weeks? ☐

Do you use contraception? _____

If so, which method do you use (please tick one or more boxes)?

Oral pill	☐	Cap (diaphragm)	☐	Cap (diaphragm)	☐
Condoms	☐	Depo provera injection	☐	Vasectomy	☐
IUCD (coil) – please state date of fitting and type of coil:_____	☐	Rhythm method	☐	Other	☐

CERVICAL SMEARS / HYSTERECTOMIES
When did you have your last smear? _____

What was the result? _____

Do you know when your next smear is due? _____

Have you ever had an abnormal smear (give details)? _____

Have you had a hysterectomy? (if so, please provide date and type) _____

LIFESTYLE FACTORS

EXERCISE

Please classify what level of exercise you currently undertake:

No exercise taken	
Exercise on average 4 times in 4 weeks	
Exercise on average 5 – 11 times in 4 weeks	
Exercise on average 12+ times in 4 weeks	
Exercise is intensive i.e. vigorous activity more than 12 times in 4 weeks (e.g. athlete)	

What type of exercise do you undertake? _____

DIET

Please indicate the sort of eating habits you have:

Diet not that healthy (could do better!)	
Healthy (mostly a diet of low fat/sugar – 5 portions of fruit / vegetables daily)	
Vegetarian or vegan	
Weight reducing	
Other (give details)	

ALCOHOL

(1 unit of alcohol = 1 pub measure of spirits OR half a pint of beer OR 1 glass of wine).

How much alcohol on average do you drink in units each week? _____

What type of alcoholic drink do you prefer? Beer / spirits / wine / other? _____

SMOKING

Do you smoke? Yes ☐ Ex smoker ☐ Never smoked tobacco ☐

What do you smoke - cigars / cigarettes / pipe / other? _____

How many, on average, each day? _____

If you used to smoke, when did you stop? _____

The doctors at the Practice strongly recommend that if you smoke, you take steps to give up smoking.
For the NHS smoking helpline call 0800 169 0 169
If you are pregnant and want to stop smoking, you can call 0800 169 9 169
For the local Hertfordshire Specialist Stop Smoking Service, call 0800 389 3 998

SURGERY LEAFLETS

The surgery stocks a number of leaflets on various medical information, however we recommend that you contact The NHS Direct on 0845 4647 and they will send you information on a much wider range of topics.

SIGNED DECLARATION (MUST BE SIGNED)

I certify that the statements and facts made in this new patient questionnaire are true to the best of my knowledge.

1. All patients over the age of 15 must sign for themselves.
2. All patients under the age of 15, the parent or legal guardian must sign.

Signed: _____ Date: _____

Capacity: Patient / Legal Guardian (please indicate).