

## New Patient Registration Details

<b>1. Title</b>	
<b>2. Surname</b>	
<b>3. Forename</b>	
<b>4. Calling name</b>	
<b>5. Date of birth</b>	
<b>6. Contact details</b>	Home: Work: Mobile: e-mail:
<b>7. Next of kin</b>	Name: Address:  Telephone:
<b>8. Relationship to you</b>	
<b>9. Are you a Carer?</b>	Yes                      No ( <i>if no, go to Q13</i> )
<b>10. If 'yes' who do you provide care for?</b>	Name: Address:  Telephone: Mobile:
<b>11. What is your relationship to that person?</b>	Wife    Husband    Mother    Father    Son    Daughter    Sibling <i>If 'other' please specify .....</i>
<b>12. Are they registered at this Surgery?</b>	Yes                      No <i>If 'yes', please ask at Reception for a Carer's consent form</i>
<b>13. Are you cared for by someone?</b>	Yes                      No ( <i>if no, go to Q16</i> ) <i>If 'yes', please ask at Reception for a Carer's consent form</i>
<b>14. Relationship to you</b>	
<b>15. Is your carer registered here?</b>	Yes                      No

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<b>16. What is your ethnic origin?</b>  Please <b>tick</b> ✓ the most appropriate	White Black Caribbean Black African Black - other non-mixed Black - other, mixed Portuguese Other non-mixed	Pakistani Indian Bangladeshi Chinese Vietnamese Other mixed I prefer not to say ( <i>decline</i> )
<b>17. What is the main language that you speak?</b>	_____ (main language)  I prefer not to give this information <input type="checkbox"/> (tick)	

**Please complete the following Health Questionnaire. If you need help, please ask at Reception**

<b>18. Height</b>	
<b>19. Weight</b>	
<b>20. Do you have a hearing impairment?</b> <i>A portable loop is available on request from Reception</i>	Yes                      No
<b>21. Are you registered blind or have poor vision?</b>	Yes                      No
<b>22. What is your smoking status?</b> <i>Please tick</i> ✓	Non-smoker Current smoker <i>How many per day? .....</i> Ex-smoker <i>When did you quit? .....</i> <b>WOULD YOU LIKE HELP TO STOP SMOKING? Y / N</b>
<b>23.</b>  <b>a) How often do you have a drink containing alcohol?</b>   <b>b) How many drinks containing alcohol do you have on a typical day when you are drinking?</b>   <b>c) How often do you have six or more drinks on one occasion?</b>	<b>PLEASE CIRCLE WHICH APPLY TO YOU</b>  <b>0</b> Never <b>1</b> Monthly or less <b>2</b> Two to four times a month <b>3</b> Two to three times per week <b>4</b> Four or more times a week _____  <b>1</b> 1 or 2 <b>2</b> 3 or 4 <b>3</b> 5 or 6 <b>4</b> 7 to 9 <b>5</b> 10 or more _____  <b>0</b> Never <b>1</b> Less than monthly <b>2</b> Monthly <b>3</b> Two to three times per week <b>4</b> Four or more times a week
	<b>TOTAL</b> _____ <b>If your total score is above 5, please ask the Receptionist for an 'Audit C' form to complete.</b>

<p><b>24. Do you take regular exercise?</b></p> <p><b>If so, please specify 'LIGHT', 'MODERATE' OR 'VIGOROUS' (see below for definitions)</b></p> <p><i>Light exercise generally allows you to talk while you're doing it, for example, going for a short walk, light housework, gardening or DIY, playing with the kids in the garden.</i></p> <p><i>Moderate exercise for 30-40mins three times a week, making you feel slightly out of breath and slightly worn out but not to the point where it is unbearable. Examples could include going for a good brisk walk, walking up a hill, carrying heavy bags back from the shops.</i></p> <p><i>Vigorous exercise should make you breathe rapidly and break into a sweat feeling like you are just at the point where you are pushing your boundaries, for example, running, cycling, swimming, playing football, exercise classes, lifting weights.</i></p>	<p><b>Please tick ✓ which applies to you</b></p> <p>LIGHT</p> <p>MODERATE</p> <p>VIGOROUS</p>
<p><b>25. Do you suffer from any allergies?</b> <i>If so, please specify</i></p>	

## IMPORTANT

**If you have any of the following conditions, please make an appointment with the Nurse:-**

- Diabetes
- Asthma
- COPD (chronic obstructive airways disease/chronic bronchitis)
- Thyroid problems
- High blood pressure
- Kidney or liver disease
- Epilepsy
- Stroke
- Taking any medication for heart problems.

If you are over 45 years of age and have not had your blood pressure taken in the last two years, please make an appointment with the Nurse.

**If you are aged 16-24 years of age, please support the National Campaign for Chlamydia Screening and ask for a testing kit at Reception or when you see the Doctor or Nurse.**

Thank you for taking the time to complete this information which will be held confidentially in your medical record.