

NEW PATIENT REGISTRATION

PRIVATE AND CONFIDENTIAL

You are joining our list and it may be some time before your records reach us. The absence of these records may impair the service which we wish to give you and we request that you complete a copy of this form for each member of your family to be registered

Present Surname

Forenames (underline name by which usually known)

Address (include Post Code)

Date of Birth (dd mm yy)

date	month	year
<input type="text"/>	<input type="text"/>	<input type="text"/>

NHS number

Married Widowed Divorced Separated Single (tick)

Date:

Telephone Numbers / Contact details

home

mobile

email

Please indicate if you would prefer not to receive text messages? Y / N

Ethnicity (2001 census National Statistics):

If you would prefer not to answer, please tick here:

British	<input type="checkbox"/>	African	<input type="checkbox"/>	White Asian	<input type="checkbox"/>
Irish	<input type="checkbox"/>	White+Blk Caribbean	<input type="checkbox"/>	Indian	<input type="checkbox"/>
Any other white	<input type="checkbox"/>	White+Blk African	<input type="checkbox"/>	Pakistani	<input type="checkbox"/>
any other mixed	<input type="checkbox"/>	Other Black	<input type="checkbox"/>	Bangladeshi	<input type="checkbox"/>
Chinese	<input type="checkbox"/>	Caribbean	<input type="checkbox"/>	any other asian	<input type="checkbox"/>
First Language spoken	<input type="text"/>				

Height:

Weight:

Usual BP (if known)

 /

Smoking - Please tick as appropriate:

Never smoked	<input type="checkbox"/>	---> When did you give up? date: <input type="text"/> ---> How many quantity: <input type="text"/>
Passive smoker	<input type="checkbox"/>	
Ex-smoker	<input type="checkbox"/>	
Current smoker	<input type="checkbox"/>	

How much alcohol do you drink per week? (include beer, spirits and wine)

(1 unit = 1 sml glass of wine or half-pint of beer)

Do you follow any special diet? (e.g. low fat)

 Y / N

What type of diet?

Do you take any regular exercise?

 Y / N

How often?

What type of exercise?

Family History - please list any major illnesses that your immediate family have had (e.g. diabetes, cancer)

Illness	family member	age when started
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Past medical history - please list any major illnesses or operations (dates can be approximate)

year	Details

Treatment drugs at present (tablets, capsules, medicines, etc.) and dosage.

1		4	
2		5	
3		6	

Please bring what you take for identifications along with container(s) and treatment card if you have one.

Give details if you are allergic or sensitive to anything such as penicillin or aspirin

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If you have been immunised against any of the following please give dates:

a)	Diphtheria	Date		
b)	Polio	Date		
c)	Tetanus	Date		
d)	MMR	Date		
e)	Meningitis	Date		
f)	Hepatitis B	Date		Immune status? <input type="text"/>
g)	Other:			
		Date		
		Date		

If you are concerned about Chlamydia (std) as your GP or practice nurse for information . Tests are free of charge,

We encourage patients of any age with long-term health problems (e.g. asthma, diabetes) or those aged over 65, to have flu and pneumococcal vaccinations

Would you like a flu vaccination?	Y / N	(every year)
Would you like a pneumococcal vaccination?	Y / N	(every 10 years)

If you are female:

Do you take the contraceptive pill?	Y / N	
Do you have an IUD / coil fitted	Y / N	---> Approximate date fitted <input type="text"/>
Have you had a cervical (cancer) smear?		
If Yes, when?	<input type="text"/>	and where? <input type="text"/>
If No, would you like one?	<input type="text"/>	

Are you a carer ? (which means : Do you provide care to a family member, partner or friends in need of help because they are ill, frail, or have a disability Y / N

If the person you care for is a patient here, we can record this in their medical records. This will require their consent
If you would like us to do this please give us the name of the individual concerned.

If you would like to attend the practice for a well-person check, or would like to discuss any of the information further, please contact the practice on 01270 - 275600

Merepark Medical Centre - Fast Alcohol Screening Test (FAST)
For Patients aged 16 or over

1. MEN: How often do you have EIGHT or more drinks on one occasion? WOMEN: How often do you have SIX or more drinks on one occasion?				
Never	Less Than Monthly	Monthly	Weekly	Daily or Almost Daily
2. How often during the last year have you been unable to remember what happened the night before because you had been drinking?				
Never	Less Than Monthly	Monthly	Weekly	Daily or Almost Daily
3. How often during the last year have you failed to do what was normally expected of you because of your drinking?				
Never	Less Than Monthly	Monthly	Weekly	Daily or Almost Daily
4. Has a relative or friend, a doctor or other health worker been concerned about your drinking or suggested you cut down?				
No	Yes, on one occasion.		Yes, on more than one occasion.	

One Standard Drink is

	Half pint of regular beer, lager or cider		1 small glass of wine		1 single measure of spirits		1 small glass of sherry		1 single measure of aperitifs
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The following quantities of alcohol contain more than 1 standard drink

						
Pint of Regular Beer/Lager/Cider	Pint of Premium Beer/Lager/Cider	Alcopop or can/bottle of Regular Lager	Can of Premium Lager or Strong Beer	Can of Super Strength Lager	Glass of Wine (175ml)	Bottle of Wine

If you have any concerns about drinking, and would like to discuss this with one of our nurses who can offer advice, please complete your details below:

Yes, please contact me by:

Phone on _____ (please complete your number)

Or Email: _____ (please let us have your email address)

OR

No, I do not wish to discuss this further:

Name: _____

Signature:

Date: