Woodbury Surgery

CONFIDENTIAL MEDICAL REGISTRATION FORM – NEW PATIENTS

PATIENT DETAILS Please complete in full using BLOCK capitals and circle where appropriate

Do you have any communication needs that we need to be aware of?	YES	NO
Are you a Veteran	YES	NO

Mr Mrs Miss Ms other:	Surname:																								
Male / Female	First name/s:																								
NHS No: (if known)											Date of Birth:														
Home Address:																									
Postcode:																									
Mobile phone number:											Work phone number:														
Home phone number:											Preferred contact method (please circle)														
											Letter					Email							SMS		
Email Address - (please enter each character / symbol in separate box)																									
Where you have provided us with a mobile number and/or email address we may use these methods to contact you regarding your healthcare e.g. appointment reminders, health checks due, health promotion and practice news																									

CARERS: a carer is someone who, without payment, provides help and support to a partner, child, relative, friend or neighbour, who could not manage without their help. This could be due to being elderly, physical or mental illness, addiction or disability.
Please also tell us if you work as a carer.

Are you a carer?	Yes	No	Do you have a carer?	Yes	No
Is the person that you care for registered at Woodbury Surgery?	Yes	No	Is the person that provides care for you registered at Woodbury Surgery?	Yes	No

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YOUR FAMILY HEALTH HISTORY

Have your parents, brother(s) or sister(s) suffered from any of the problems listed below- Please tick and then **circle which family member**

Diabetes		Father / Mother / Sister / Brother
Asthma		Father / Mother / Sister / Brother
High Blood Pressure		Father / Mother / Sister / Brother
Stroke		Father / Mother / Sister / Brother
Heart Disease		Father / Mother / Sister / Brother
Cancer		Father / Mother / Sister / Brother

YOUR OWN HEALTH

HEALTH PROBLEMS: Please tick if you have a history of any of the following health problems:

Cancer		Coronary Heart Disease, Heart Failure, or Artrial Fibrillation	
Dementia or Alzheimer's		Depression or Mental Health problems	
Hypertension (High Blood Pressure)		Kidney Disease	
Respiratory Difficulties (Asthma or COPD)		Stroke or Transient Ischemic Attacks	
Diabetes		Learning Difficulties	
Epilepsy		Thyroid Disease	
If you have any other history or important illnesses or disabilities not mentioned above please give details here:			

IMMUNISATIONS

Immunisation	Year	Immunisation	Year
Tetanus		Polio	
Typhoid		Yellow Fever	
Hepatitis A		Hepatitis B	

ALLERGIES

Name of medication	What was the problem or upset?		
Please indicate if you have an allergy to:	Peanuts	Eggs	Latex

MEDICATION

Are you taking any regular / repeat medication? If so please make a list below OR attach the most recent repeat prescription list from your previous GP surgery, this information is essential to enable your new GP to authorise future repeat medication.		

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FOR FEMALES AGED 15 TO 65				
Are you currently, or think you might be, pregnant?			Yes	No
Do you have any children?	Yes	No	If Yes how many?	
Which method of contraception (if any) are you using at present?				
If you do use contraception when was your last check-up / review with GP or Nurse?			Date:	
If you have a Coil or implant approximately what date was it fitted?			Date:	
If you have depot injections when was your last one?			Date:	
Have you had a recent smear?			Date:	

PATIENTS AGED 85 OR OVER (this is to help us assess if you need additional clinical input)

In general do you have any health problems that require you to limit your activities?	Yes	No
In general do you have any health problems that require you to stay at home?	Yes	No
Do you regularly use a stick, walker or wheelchair to get about?	Yes	No
In case of need, can you count on someone close to you?	Yes	No
Do you need someone to help you on a regular basis?	Yes	No
Please provide details if the person is different from the information you have provided as your carer:		

NEXT OF KIN

Title/Name:					
Address:					
Mobile		Landline		Relationship to you	

YOUR ETHNICITY AND LANGUAGE

The NHS requires all medical records to show patients ethnic origin together with native or first language.
Please tick the appropriate box:

WHITE: British or Mixed British		ASIAN: Pakistani or British Pakistani	
WHITE: Irish		ASIAN: Bangladeshi or British Bangladeshi	
WHITE: Any other background		ASIAN: Any other background	
MIXED: White and Black Caribbean		BLACK: Caribbean	
MIXED: White and Black African		BLACK: African	
MIXED: White and Asian		BLACK: Any other background	
MIXED: Any other background		CHINESE:	
ASIAN: Indian or British Indian		ANY OTHER ethnic group	
What is your first spoken language?		I prefer not to specify my ethnic group.	
Do you require a translator? (Xal8X)	YES NO (please circle)		

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We will record your first spoken language as ENGLISH unless you specify otherwise.

YOUR LIFESTYLE

YOUR ALCOHOL CONSUMPTION Please circle 1 answer on each of these rows:	SCORE 0	SCORE 1	SCORE 2	SCORE 3	SCORE 4
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 if female, or 8 or more If male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

YOUR SMOKING STATUS (Please tick boxes and complete with information as appropriate)

Never Smoked		N/A		
Ex- Smoker		Date Stopped?		
Cigarette Smoker		How many per day?		
Roll Own Cigarettes		How many per day?		
Cigar Smoker		How many per day?		
Pipe Smoker		How many ounces per week?		
e-Cigarette		Would you like help to quit smoking?	Yes	No

EXERCISE

Do you exercise regularly?	Yes	No	If yes please answer the following questions
What type of exercise do you do?			
How often do you exercise?			

Height		Weight	

CONSENT

Your information will be stored on a confidential clinical database. It is your choice which of this information is shared with other NHS services. Please read the enclosed '**SHARING YOUR NHS PATIENT DATA'** and complete and sign the form '**NHS PATIENT INFORMATION SHARING – MY CHOICES'.**
If you have provided us with a mobile number and/ or an email address it is your responsibility to inform us immediately of any change to this information and to maintain the security of your phone/ computer. **Please note by signing this form you are consenting to receiving texts and emails from the practice regarding your health care.**

SIGNATURE OF PATIENT :	
OR SIGNATURE on behalf of a patient:	
DATE:	