* Complete ALL parts of the questionnaire
* Provide proof of identity – please be advised that a copy will be taken and stored in the patient’s electronic medical record
* Sign and date your registration form
* Patients over the age of 15 years need to attend for a new patient check with a Practice Nurse

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| Personal information |
| Surname: | Forenames: |
| Date of birth: | Age: |
| Address: |
| Post code: | Your occupation: |
| Tel no (home): | Tel no (mobile): |
| Email address: |
| Nationality/Ethnicity | First language spoken: |
| Next of kin:Relationship to you:Next of kin telephone number: |

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| Carer information |
| Do you have a carer that helps you with your personal needs?  | Yes 🞏 | No 🞏 |
| *If yes, please give details of who looks after you* |
| Surname: | Forename: |
| Tel no (home): | Tel no (mobile): |
| Relationship to you: |
| Are you a carer? | Yes 🞏 | No 🞏 |
| *If yes, please give details of who you look after* |
| Surname: | Forename: |
| Tel no (home): | Tel no (mobile): |
| Relationship to you: |

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| Medical conditionsplease indicate whether you currently have, or have had, any of the following conditions:- |
| Angina 🞏 | Asthma 🞏 | Chronic kidney disease 🞏 |
| COPD 🞏 | Diabetes | Type 1 🞏 | Epilepsy 🞏  |
| Type 2 🞏 |
| Heart attack 🞏 | Hypertension 🞏 | Mini stroke / TIA 🞏 |
| Rheumatoid Arthritis 🞏 | Stroke 🞏 |  |

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| General information |
| What is your height: | What is your weight: |
| Exercise | What form of exercise do you undertake: |
| How many times a week do you exercise |
| For minutes per session |
| Smoking |
| Do you currently smoke? | Yes 🞏 | No 🞏 |
| If yes, how many do you smoke per day: |
| At what age did you start smoking: |
| Are you an ex-smoker? | Yes 🞏 | No 🞏 |
| If yes, when did you quit smoking: |

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| Alcohol |
|  | **0** | **1** | **2** | **3** | **4** | **Score***Office use* |
| How often do you have a drink containing alcohol? | Never 🞏 | Monthly or less 🞏 | 2-4 times a month 🞏 | 2-3 times a week 🞏 | 4 or more times a week 🞏 |  |
| How many standard drinks containing alcohol do have on a typical day when you are drinking? | 1or 2 🞏 | 3 or 4 🞏 | 5 or 6 🞏 | 7 or 8 🞏 | 10 or more 🞏 |  |
| How often do you have 6 or more standard drinks on one occasion? | Never 🞏 | Less than monthly 🞏 | Monthly 🞏 | Weekly 🞏 | Daily or almost daily 🞏 |  |
| **Total score** |  |
| *Please note: You may be asked further questions regarding your drinking habits when you attend the surgery, or you may be contacted by telephone regarding your drinking habits if your answers to the above alcohol related questions suggest that you might be at risk of harm from alcohol.* |

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| Allergies |
| Allergies to any known medication | Yes 🞏 | No 🞏 | Specify: |
| Allergies to other known things | Yes 🞏 | No 🞏 | Specify: |
| Have you ever had a severe allergic reaction | Yes 🞏 | No 🞏 | What did you react to? |
| How did you react? |

|  |
| --- |
| Prescribed medication |
| Please obtain and supply us with a list of your medications from your previous GP – attach to this questionnaire. |
| It is expected that all our patients should use electronic prescriptions following NHS Guidance, please tick below which chemist you would like your prescriptions to go to.Honley Chemist 🞏 Other Chemist 🞏 (Please give Chemist name and address)………………………………………………………………………………………………………………………………………………………………………………………………………………………….………………………………………………………………………………………………………………….…………………………………………………………………………………………………………………. |

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| Women only |
| Contraception | If used, please specify what type of contraception you use: |
| Cervical cytology | Date of your last cervical screening: |

|  |  |
| --- | --- |
| **The information supplied by me is correct** | Date: |
| Signature: | Full name: |
| **Office use** Form checked by (Receptionist name):Proof of identity provided (please list): |

Updated: March 2020