Wollaton Park Medical Centre
New Patient Registration Form

Name:
Today's Date:

Please complete this confidential questionnaire (one for each member of the family to be registered with the Practice).

Please complete in BLOCK CAPITALS and tick the boxes as appropriate.

If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.

Each registration will need to be handed in with proof of address (utility bill etc. within the past 3 months) and also a form of photo ID (Passport, Driving license etc.)

Mr / Mrs / Miss / Ms / Other...	**Address and Postcode:**	**Date of Birth:**
Full Name:		**Gender:**

Telephone Number:	**Mobile Number:**	**Work Number:**	**E-mail Address:**
NHS Number (if known):	**Next of Kin and their relationship to you:**	**Next of Kin Contact Number:**	**Town & Country of Birth:**

Marital Status:	**Occupation:**	**Names & Ages of Children:**
Other Residents at your home address:		

Your height:	**Feet/Inches**	**cm**	**Your weight:**	**Stones/lbs**	**kg**

Your religion:	**Church of England**	**Catholic**	**Other Christian (state)**	**Hindu**	**Buddhist**	**Muslim**
	Sikh	**Jewish**	**Jehovah's Witness**	**No religion**	**Other religion (state)**	

Your Ethnic Origin: (select one)	**White (UK) 9i0**	**White (Irish) 9i1%**	**White (other) 9i2%**	**Caribbean 9i3**	**African 9i4**
African 9i4	**Asian 9i5**	**Other mixed back-ground 9i6**	**Indian/ British Indian 9i7**	**Pakistani/ British Pakistani 9i8**	**Bangladeshi/ British Bangladeshi 9i9**
Other Asian Back-ground 9ia	**Other Black Background**	**Chinese 9ie**	**Other 9if**	**Ethnic Category not stated 9ig**	

Your main or 1st language Spoken/ Understood	**English**	**Hindi**	**Gujarati**	**Urdu**	**Punjabi**	**Polish**	**French**	**German**
	Spanish	**Other (please specify)**						

Smoking and Exercise:

Are you currently a smoker?	**Yes**	**No**	**Have you ever been a smoker?**	**Yes**	**No**
If so, how many cigarettes/cigars/ tobacco ounces do you smoke in a week?			**Would you like information on how to stop smoking?**	**Yes**	**No**
How often do you exercise?			**How long do you exercise for?**		

This is one unit of alcohol:

… and each of these are more than one unit:

Questions	**Scoring system**					**Your score**
	0	**1**	**2**	**3**	**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	

Scoring: **My Score is:**

If you score 5 or more can you please complete the second questionnaire below…..

Questions	**Scoring system**					**Your score**
	0	**1**	**2**	**3**	**4**	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0 – 7 No further action, 8 – 15 Make a 10 minute appointment to see a Practice Nurse 16 – 19, Make a 20 minute appointment to see a Practice Nurses, 20+ Make a double appointment to see a GP **My Score is:**

Your Medical Background										
Have you had any of the following conditions and when?	Atrial Fibrillation		Heart Disease		Hypertension		Stroke		Diabetes	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

High Blood Pressure		Hypothyroidism		Asthma		COPD		Dementia		Depression	
Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

Cancer		Osteoporosis		Mental Health		Learning Disabilities		Rheumatoid Arthritis		Cardio Vascular Disease	
Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

Chronic Kidney Disease		Epilepsy date of last seizure		
Yes	No	Yes	No	Date:

What operations have you had and when?							
Please list any tablets, medicines or other treatments you are currently taking (inc dose & frequency							
Are you able to administer your own medicines?	Yes	No - please detail specific issues (e.g. swallowing, opening containers)					
Are there any serious diseases that affect your parents, brothers or sisters (tick all that apply)	Diabetes	Heart Attack	Heart attack under age of 50	Bowel Cancer	Breast Cancer	Asthma	
	High Blood Pressure	Stroke	Thyroid Disorder	Any other important Family Illness?			
What immunisations have you had? (please tick all that apply)	Diphtheria	Measles	German Measles	Tetanus	Polio	MMR	Whooping Cough
	Pre-school booster	Triple vaccine (Diphtheria, tetanus & Pertussis)- 3 doses					

Specific Needs:
Please detail below any specific needs you have so the practice can ensure they are identified and accommodated by taking the appropriate action:

Please state any Sensory Impairment you have (i.e Speech, Hearing, Sight):	
Are you an 'Assistance Dog' User?	
Please state any physical disabilities you have	
Please state any Mental disabilities you have:	
Do you require the help of a Translator/ Interpreter?	
Please state any allergies and sensitivities you have:	

If you are a Carer, please state the name/address/ phone number of the person you care for:	**Person Cared for Contact Details:**	
If you have a Carer, please state their name/ address/phone number and sign here if you wish us to disclose information about your health to your carer	**Carer Contact Details:**	
	Signed:	**Date:**

Do you have a "Living Will" (a statement explaining what medical treatment you would not want in the future)	Yes / No
	If 'Yes' can you please bring a written copy of it to your next GP appointment
Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attor-ney)	Yes / No
	If 'Yes' can you please bring a written copy of it to your next GP appointment

Women only:

When was your last smear done?	Date	Was this at your GP's surgery?	Yes	No	Date of last mammogram (if applicable)	Date
What was the result of the smear?		Do you wish to see a doctor in this practice for contraceptive services (including the pill, coil, implant)	Yes	No		
Method of contraception (if used)						

Summary Care Records

A Summary Care Record is a brief electronic (computerised) summary which contains information about the **medication** you take, **allergies** you suffer from and any **adverse reaction to medications** you may have. This information **is shared with emergency services** such as A & E or the Out of Hours GP services so that they may treat you safely but does not give the emergency services full access to your medical records. **The standard setting is to Share (Opt IN).**

Are you happy to have a Summary Care Record?	Yes	No	More time required to decide:

Patient Signature:		Signature on behalf of patient:	

We offer online appointment booking and ordering of repeat prescriptions. Would you like the login details to join this service?	Yes	No

Thank you for completing this form

For more information about the services we offer, please see our Practice leaflet or see our website www.wollatonparkmedicalcentre.co.uk