New Patient Registration Information

As there is a delay in receiving your medical records, you can help the doctors and staff by completing this form.
The information on this form will be treated confidentially and will form part of your medical records. **It is important to be forthright and accurate in the details given.** This for is ***only*** for use within the surgery and the information given on it will not be given to any other person or official body without your permission.

OFFICE USE ONLY
EMIS No:
NPMED:
MEDS:
IMMS:
SMEAR

NEW PATIENT - PERSONAL DETAILS

Sex: Male / Female
Date of birth:.....
Title:..... **Forename(s):**.....
Surname:.....
Status: MARRIED / SINGLE / WIDOWED / DIVORCED
Maiden or former name(s):.....
Ethnicity:.....
Place of birth: .....
First language: .....
Carer: YES / NO
Interpreter required: YES / NO
Military veteran: Yes / No

Address: .....
.....
Postcode:.....
Previous address: (if not 5 years at present address) .....
.....
.....
Home Tel No:.....
Work Tel No:.....
Mobile Tel No: .....
Your occupation: .....
Name and address of your previous doctor: .....
.....
.....

Next of kin:.....**Relationship to patient:**.....
Next of kin address:.....
.....**Next of kin tel. no:**.....

NEW PATIENT – HEALTH

Do you take regular exercise? YES / NO If so, please give details: .....
Do you smoke? YES / NO If so, how much/many? .....
Do you drink alcohol? YES / NO If so, how much/many? .....
Do you have any allergies? YES / NO If so, please give details: .....
What kind of diet do you follow? MIXED / VEGETARIAN / VEGAN

NEW PATIENT – MEDICAL HISTORY

Have you or do you suffer from any of the illnesses below? If yes, please add the year that you were ill next to the illness.

T.B: YES / NO .....
DIABETES: YES / NO .....
STROKE(s): YES / NO .....
ASTHMA: YES / NO .....
EPLILEPSY: YES / NO .....

HIGH BLOOD PRESSURE: YES / NO .....
RECURRING BRONCHITIS: YES / NO .....
NERVOUS ILLNESS: YES / NO .....
HEART DISEASE: YES / NO .....
DEPRESSION: YES / NO .....

Do you take any form of medication/tablets? YES / NO If so, please give details:.....
.....

P.T.O

NEW PATIENT – FURTHER MEDICAL DETAILS

Please give details of any other important illnesses, operations, accidents or hospital admissions complete with the name of the hospital and the date it happened:.....

.....

.....

Are you currently attending any hospital?.....

Please give the name, address and department of the hospital and reason for attending(if applicable)**:**

.....

.....

NEW PATIENT – FAMILY HISTORY

Please tick appropriately:

	FATHER	MOTHER	BROTHER	SISTER
DIABETES				
ASTHMA				
HIGH BLOOD PRESSURE				
BRONCHITIS				
STROKE / TRANSIENT ISCHEMIC ATTACK				
HEART DISEASE				

NEW PATIENT – WOMEN ONLY

Have you ever been pregnant? YES / NO **If so, how many times?**.....

Have you ever had a miscarriage? YES / NO **If so, how many times?**.....

Did you experience any complications during your pregnancy? YES / NO

Details:.....

Do you take the contraceptive pill? YES / NO **Do you have a coil fitted?** YES / NO

Any period related problems?..... **When was you last cervical smear?** .....

NEW PATIENT – BABIES ONLY

Birth weight:..... **Type of delivery:**..... **Did he/she require any special care?** .....

Any problems?.....**Complications in pregnancy?** .....

NEW PATIENT – CHILDREN ONLY (UNDER 16

Which school is he/she attending?.....

Please indicate if he/she has any of the following vaccinations:

DIPTHERIA YES / NO **BCG** YES / NO **WHOOPING COUGH** YES / NO **TETANUS** YES / NO

MEASLES YES / NO **POLIO** YES / NO **GERMAN MEASLES** YES / NO **SMALLPOX** YES / NO

Summary care record optout: Yes / No

e.care record : opt out GP upload Yes / No Opt out Social care record Yes / No

E mail addressd:.....

Permission to text: Yes / No **Best time to ring: morning / evening / any time**