Patient registration and health questionnaire

Title: (Mr, Mrs, etc.)		**Date of birth**	
Forename(s)			
Surname		**Previous surname**	
Calling name		**Occupation**	
Current address			
Home phone number		**Mobile phone number**	
Email address			
NHS number			
Previous address			
Previous GP			
Have you been registered here previously? If yes, please give dates.			
Have you moved to the UK from abroad? If yes, give date of arrival in the UK.			
Next of kin details: **Title:** **Surname:** **Forename:** **Relationship:** **Address:** **Telephone numbers:**			
Armed Forces veterans' service: **Dates of service:** **Discharge date:** **Address prior to serving:**			
Special circumstances:	Please tick if any of the following apply: I have a carer I am a carer Asylum seeker Housebound Live in a nursing home Live in a residential home Live in a community psychiatric home Live in a children's home		
Height		**Weight**	
Allergies		**Disabilities**	
Are you: **Registered blind or partially sighted** **Registered deaf**		Please state which of these apply:	

Registered disabled	
Please state your ethnicity	
Do you have any drug allergies? ***Please include known reactions***	
Do you have any other allergies? ***Please give as much detail as possible***	
Do you suffer from any of the following: **Heart disease** **Hypertension** **Asthma** **Diabetes** **COPD** **Chronic kidney disease** **Epilepsy** **Stroke** **Cancer**	Please state which of these apply and give date of last review:
Do you have any other serious or chronic illness?	Please explain:
Do you have a family history of: **Diabetes** **Heart disease** **High cholesterol** **Heart attack** **Stroke** **Cancer**	Please give details including relationship, illness and age at diagnosis if known:
Have you had any significant injuries or major operations?	If yes, please give details:
Smoking status – Are you: **A current smoker** **An ex-smoker** **A non-smoker**	If a current or ex-smoker, please give details of how many you smoke or smoked per day. If you are an ex-smoker please give the date you stopped (month / year).
Smoking cessation advice is available. Would you like further information?	If yes, please ask at reception or see our website for details.
How many units of alcohol do you drink on a typical day when you are	Please tick which applies: 1-2

drinking? (1 unit = ½ a pint or a small glass of wine or a single pub measure of spirits)	3-4 5-6 7-9 10+
How often have you drunk more than 8 units (men) or 6 units (women) on a single occasion in the past year?	Please tick which applies: Never Daily Weekly Monthly Less often than monthly

Alcohol scoring system	0	1	2	3	4	Score
How often do you drink 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 drinking?	1-2	3-4	5-6	7-9	10+	
How often have you drunk more than 8 units (men) or 6 units (women) on a single occasion in the past year?	Never	Less often than monthly	Monthly	Weekly	Daily or almost daily	

Advice is available if you would like to reduce your alcohol intake.	Please ask at reception or see our website for details.		
Current medication	If possible, attach a copy of your repeat prescription list.		
Medication	Dosage	Repeat	Quantity remaining

Females only:	
Date of last cervical smear	
Contraception used	
Over 65s:	
Have you had a pneumonia vaccine in the last 10 years?	
Have you had a flu vaccine this year?	

Consent: (Please delete as appropriate)	I consent/do not consent, to be contacted by SMS on my mobile number I consent/do not consent, to be contacted by email at this address We may contact you with appointment details, results, health awareness events, etc.

	I consent/do not consent, to share Summary Care record (SCR are electronic record of important patient information, created from GP medical records. They can be seen and used by authorised NHS staff directly involved in the patient's care)

Please use this space to give any other information you feel is appropriate:

PATIENT DECLARATION	
I confirm that, to the best of my knowledge, the information I have provided is accurate and correct.	
Signature	
Print name	
Date	

Thank you for completing this form.

Please return this form to a member of the reception team who will make an appointment for your new patient health check.

Patient registration and health questionnaire - Child

Gender:		**Date of birth**	
Forename(s)			
Surname		**Calling Name**	
Current address			
Home phone number			
School			
NHS number			
Previous address			
Previous GP			
Has your child been registered here previously? If yes, please give dates.			
Has your child moved to the UK from abroad? If yes, give date of arrival in the UK.			
Parent or guardian details: **Title:** **Surname:** **Forename:** **Relationship:** **Address:** **Telephone numbers:**			
Consent: (Please delete as appropriate)	I consent/do not consent to be contacted by SMS on my mobile number I consent/do not consent to be contacted by email at this address We may contact you with appointment details, results, health awareness events, etc.		
Special circumstances:	Please tick if any of the following apply to your child: I have a carer I am a carer I have communication difficulties Asylum seeker Housebound		

	Live in a nursing home Live in a residential home Live in a community psychiatric home Live in a children's home		
Height		**Weight**	
Allergies		**Disabilities**	
Is your child: **Registered blind or partially sighted** **Registered deaf** **Registered disabled**	Please state which of these apply:		
Please state your child's ethnicity			
Does your child have any drug allergies? ***Please include known reactions***			
Does your child have any other allergies? ***Please give as much detail as possible***			
Does your child suffer from any of the following: **Asthma** **Depression** **Diabetes** **Epilepsy**	Please state which of these apply and give date of last review:		
Does your child have any other serious or chronic illness?	Please explain:		
Does your child have a family history of: **Asthma** **Diabetes** **Heart disease** **High cholesterol** **Heart attack** **Stroke** **Cancer** **Liver Disease** **Depression** **Epilepsy** **COPD**	Please give details including relationship, illness and age at diagnosis if known:		
Has your child had any significant injuries or major operations?	If yes, please give details:		

Current medication	If possible, attach a copy of your child's repeat prescription list.
Medication	Dosage / Repeat / Quantity Remaining

PARENT OR GUARDIAN DECLARATION	
I confirm that, to the best of my knowledge, the information I have provided is accurate and correct.	
Signature	
Print name	
Date	

Please note, it is your responsibility to keep the practice up to date with any changes to your address, telephone number or email address.

Thank you for completing this form.

Please return this form to a member of the reception team who will make an appointment for your new patient health check.