PLEASE ENSURE PROOF OF ADDRESS AND IDENTITY IS ATTACHED

Collected by (initials)	Who	Date	Time
Processed by			

EMIS NUMBER:

U.K RESIDENTS REGISTRATION FORM

PLEASE COMPLETE IN BLOCK CAPITALS
LEGIBLY & *IN FULL* OTHERWISE
WE CANNOT PROCESS YOUR REGISTRATION

NHS NUMBER: (PLEASE NOTE THIS IS **NOT** YOUR NATIONAL INSURANCE NUMBER)

MR ☐ MRS ☐ MISS ☐ MS ☐

Date Of Birth D D M M Y Y Y Y

First name

Middle name

Surname

Previous surname

☐ MALE ☐ FEMALE

Home phone

Mobile phone

Email address

Home address:

Postcode

Town of birth

Previous home address

Postcode

Signature: ______________________________

Date: __ / ___ / _____

THIS INFORMATION IS REQUIRED TO ALLOW US TO TRACE YOUR MEDICAL RECORDS – PLEASE FILL IN ALL BOXES

NAME OF PREVIOUS GP: (e.g. Dr Kershaw)

NAME OF PREVIOUS G.P PRACTICE:

ADDRESS OF PREVIOUS GP PRACTICE:

IF YOU ARE RETURNING FROM THE BRITTISH ARMED FORCES :

ADDRESS BEFORE ENLISTING

SERVICE NUMBER

ENLISTMENT DATE

NEXT OF KIN/ EMERGENCY CONTACT DETAILS (N.OK):

Name of NOK	
Relationship	
Home phone	
Mobile phone	

IN THE EVENT OF AN EMERGENCY CAN WE CONTACT THIS PERSON?

☐ YES ☐ NO

NEW PATIENT HEALTH QUESTIONNAIRE

PLEASE COMPLETE THIS QUESTIONNAIRE ALONG WITH ANY OTHER INFORMATION YOU FEEL WE SHOULD KNOW

ALL INFORMATION IS TREATED IN STRICT CONFIDENCE

HOW TALL ARE YOU? ________________ CM

HOW MUCH DO YOU WEIGH? ____________ KG

BLOCK PRESSURE READING ☐ / ☐

TO RECORD YOUR WEIGHT AND UP TO DATE BLOOD PRESSURE VISIT OUR 'POD' ROOM LOCATED ON THE 1ST FLOOR WHERE YOU CAN MEASURE AND RECORD THEM.

SMOKING HISTORY **CURRENT SMOKER** ☐ **EX SMOKER** ☐ **NEVER SMOKED** ☐

PLEASE CIRCLE – CIGARETTES - TOBACCO - CIGARS - PIPE

EX SMOKER – WHEN DID YOU STOP SMOKING (DD, MM, YYYY)? ___________________________

WE PRIDE OURSELVES ON HELPING, SUPPORTING AND ACTIVELY ENCOURAGING SMOKERS TO 'QUIT' AND CAN PROVIDE ONE TO ONE IN HOUSE SUPPORT AND THERAPY. WOULD YOU LIKE ONE OF OUR SMOKING CESSATION ADVISERS TO CONTACT YOU? YES ☐ **NO** ☐

ARE YOU ALLERGIC TO ANY MEDICINES – E.G PENICILLIN OR ASPIRIN?

PLEASE LIST ANY SERIOUS ILLNESS OR OPERATION YOU HAVE HAD, AND THEY YEAR IT OCCURED

PLEASE BRING IN A COPY OF YOUR REPEAT PRESCRIPTION TO YOUR FIRST GP APPOINTMENT

IF YOU ARE OVER THE AGE OF 40 IT IS THE POLICY OF THE PRACTICE TO COMPLETE AN NHS HEALTH CHECK. PLEASE BOOK YOUR APPOINTMENT A WEEK AFTER YOU HAVE HANDED IN THIS REGISTRATION form.

NHS ORGAN DONOR REGISTRATION

I WANT TO REGISTER MY DETAILS ON THE NHS ORGAN DONOR REGISTER AS SOMEONE WHOS ORGANS/TISSUE MAY BE USED FOR TRANSPLANTATION AFTER MY DEATH. PLEASE TICK THE BOXES THAT APPLY:

Any of my organs and tissue ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐

Pancreas ☐ Any part of my body ☐ Signature________________ Date _______________

NHS BLOOD DONOR REGISTRATION

I WOULD LIKE TO JOIN THE NHS BLOOD DONOR REGISTER AS SOMEONE WHO MAY BE CONTACTED AND WOULD BE PREPARED TO DONATE BLOOD:

TICK HERE IF YOU HAVE GIVEN BLOOD IN THE LAST THREE YEARS. ☐ **YES**

SIGNATURE CONFIRMING CONSENT TO INCLUSION ON THE NHS BLOOD DONOR REGISTER

SIGNATURE _______________ **DATE**_______________

NEW PATIENT HEALTH QUESTIONAIRE CONTINUED

PLEASE HELP US PLAN FOR THE FUTURE HEALTHCARE OF OUR POPULATION BY PROVIDING INFORMATION ON YOUR ETHNICITY. PLEASE CIRCLE ONE ONLY

WHITE	BRITISH
	IRISH
	ANY OTHER WHITE BACKGROUND
MIXED	WHITE AND BLACK CARIBBEAN
	WHITE AND BLACK AFRICAN
	WHITE AND ASIAN
	ANY OTHER MIXED BACKGROUND
ASIAN OR ASIAN BRITISH	BANGLADESHI
	INDIAN
	PAKISTANI
	ANY OTHER ASIAN BACKGROUND
BLACK OR BLACK BRITISH	CARRIBBEAN
	AFRICAN
	ANY OTHER BLACK BACKGROUND
OTHER ETHNIC GROUPS	CHINESE
	ANY OTHER ETHNIC GROUP
DECLINE TO PROVIDE ETHNIC GROUP	

WHAT IS YOUR FIRST LANGUAGE? ………………………………………………………………………..

ANY OTHER APPROPRIATE INFORMATION YOU FEEL WOULD BE USEFUL

Before handing this form back please check:

☐ Form is completed in **Full** and is **Legible**

☐Proof of address and ID is attached

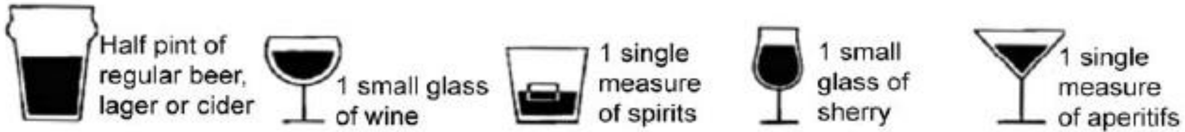
•Please wait at least 48 hours (2 working days) before making an appointment.

•Please bring your repeat medication list to your first GP appointment, plus any other relevant information.

WE OFFER ONLINE ACCESS (once you are registered) TO BOOK APPOINTMENTS, REQUEST PRESCRIPTIONS AND VIEW RECORDS - PLEASE ASK AT RECEPTION on your first visit

ALCOHOL INTAKE

PLEASE ANSWER THE FIRST FOUR QUESTIONS



EACH OF THE ABOVE IS ONE UNIT OF ALCOHOL

EACH OF THESE IS MORE THAN ONE UNIT OF ALCOHOL

How many units of alcohol do you have a week?

PLEASE CIRCLE THEN ADD UP YOUR SCORE BELOW

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	

YOU ARE VERY WELCOME TO MAKE AN APPOINTMENT WITH THE NURSE OR DOCTOR TO DISCUSS YOUR ALCOHOL COSUMPTION AT ANY STAGE; IN TURN WE MAY CONTACT YOU IF THERE ARE ANY CONCERNS.

ADD UP SCORES IN 3 BOXES ABOVE & PUT TOTAL IN HERE

TOTAL AUDIT C

IF YOU HAVE SCORED 5+ IT MAY INDICATE HAZARDOUS OR HARMFUL DRINKING. PLEASE THEN COMPLETE THE MORE DETAILED AUDIT OVERLEAF

IF YOU HAVE SCORED LESS THAN 5 THERE IS NO NEED TO ANSWER THE QUESTIONS OVERLEAF AND YOU MAY HAND YOUR FORM BACK TO A RECEPTION DESK.

ONLY COMPLETE IF SCORE ON PREVIOUS PAGE IS 5 OR MORE

Remaining alcohol questions

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	

ABOVE TOTAL

Total Audit C (FROM PREVIOUS PAGE)

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 higher risk, 20+ possible dependence

TOTAL Score equals
AUDIT C Score (Previous page)+
Score Above