CHURCH ELM LANE MEDICAL PRACTICE

New Patient Registration Questionnaire

False or incorrect information may jeopardize your acceptance to this practice.
In the case of a child, parent(s) or carer must complete the questionnaire for them.

DOCUMENT CHECKLIST (**surgery use only**)			
	Type of document (passport/bill etc)	Checked	Details
PHOTO ID			
PROOF OF ADDRESS			
BIRTH CERTIFICATE			
CHILD HEALTH BOOK			
ANY OTHER ID			

Documents checked by: …….. Date ……

Patient registered on system by: …… Date ……

***** Delete where applicable

*Mr/Mrs/Miss/Master	First name(s):	Surname:
Date of Birth:	Place of Birth:	Email:
Address:		
Post Code:	Home Telephone:	Mobile:

NEXT OF KIN DETAILS/ NEAREST RELATIVE TO CONTACT IN CASE OF AN EMERGENCY (MUST BE OVER 18 YEARS OF AGE)

Name:	Relationship:	
Address:		
Post Code:	Home Telephone:	Mobile:

PREVIOUS REGISTRATION DETAILS

Previous GP:	Address:
Reason for leaving:	Why register with this practice:
Have you ever been registered here? * YES / NO	
If yes when did you leave the practice?	

PLEASE CIRCLE WHICH ETHNIC GROUP YOU BELONG TO:

White British	White Irish	Other White background	White Black Caribbean	White Black African	
White Asian	Other mixed Ethnicity	Bangladeshi	Pakistani	Indian	Other mixed background
Caribbean	African	Other Black	Chinese		

Other Ethnic Group please state:	
Country of Origin	
Date Arrived in the United Kingdom	

Your Religion:	First Language spoken:

LIFESTYLE

Occupation/Job:	Work Telephone No.:
Do you drink Alcohol?	If yes, how much per week:
Do you smoke?	If yes, how many per day
Smoking Damages your health. Would you like some advice on quitting?	
Do you exercise regularly? If yes what exercise do you do?	
Have you ever used/or currently use any hard drugs?	

MEDICAL HISTORY

Please give details of any operations you've had.

Do you suffer from any of the following? Please tick & give the date of diagnosis.

CHD	Heart Failure	Stroke & TIA	Hypertension	Diabetes	COPD	Epilepsy
Hypothyroidism	Cancer	Palliative Care	Mental Health	Asthma	Dementia	Depression
Chronic Kidney Disease	Atrial Fibrillation	Obesity	Osteoporosis	Learning Disabilities	Chest/Heart condition	Allergies
Any family history of the above? Please give brief details:						
Please give names & dosage of any current medication:						
If you are currently under the care of a Hospital please give brief details:						

IMMUNISATIONS

Are you immunised against any of the following. Pease tick and put dates if known.

Polio	Tetanus	Diphtheria	Whooping Cough	MMR	Meningitis	Don't Know
Any Other:						

Have you ever had any of the following illnesses please tick and give dates if known.

Chickenpox	Mumps	Measles	German Measles	Scarlet Fever	Whooping Cough	Rheumatic Fever	Poliomyelitis

Have you been tested for HIV:	Date of testing:
Have you been tested for Tuberculosis (TB):	Date of testing:

DISABILITY

Do you have a registered disability or have a learning disability? YES/NO Please give details:		
Do you have a Carer? If yes please give	Name:	Contact Telephone No.:
Are you a Carer? If yes	Who do you care for?	What is their relationship with you
Do you consent for us to contact your carer if we cannot get hold of you? YES/NO		
Do you consent to sharing your medical information with other medical providers, i.e. hospitals, community treatement teams etc, regarding your disability when required? YES/NO		

If you require any communication assistance due to your disability, i.e. large print, British Sign Language interpreters, braille or easy-read documents, please let reception know when you come to register.

TO BE COMPLETED BY WOMEN ONLY

Are you pregnant? If yes, please give:

Date of delivery:	Hospital booked into:	
Please give details of last Cervical Smear	Date:	Result:
Please give details of last Mammogram if any	Date:	Result:

Signature of Patient/Guardian…….