ALBYN MEDICAL PRACTICE
NEW PATIENT REGISTRATION QUESTIONNAIRE: AGED 16 AND OVER

PLEASE COMPLETE THIS 4-PAGE QUESTIONNAIRE – YOUR REGISTRATION MAY BE DELAYED IF YOU DO NOT SUPPLY ALL RELEVANT INFORMATION

Personal Details

Surname	First Names
Address	Post Code
Home Tel. No	Mobile Tel. No.
Date of Birth	Male / Female (*please circle*)
Occupation	Single / Married / Separated / Widowed / Co-habiting
Email address	

Do you live with your family at the above address Yes / No

Do you live with other people to whom you are not related Yes / No

Do you look after any relatives not living with you Yes / No

Please provide details of other members of your FAMILY household registering with us:

Name:	**Date of Birth:**	**Relationship to you:**

If you have recently arrived in this country please provide the following information:	
Which country have you come from:	**The date you arrived in the UK:**
How long you expect to stay in the UK:	**Your Place of Birth:**

Please circle as appropriate: Worker / Student / Dependant / Other

If you are a student, please state which course……

Please state the date your course finishes ……..month/year

CHILDREN UNDER 17 YEARS OLD: please give details of current school attended:

……

Does you need an interpreter YES / NO

If yes, please state what language you speak ……

Does you need sign language support? YES / NO

WHAT IS YOUR ETHNIC GROUP?
Tick **ONE** box which **best describes** your ethnic group or background

A White

□ Scottish □ English □ Irish □ Northern Irish
□ British □ Welsh □ Polish
□ Any other white ethnic group, please write in .....

B Mixed or multiple ethnic groups	**C Asian, Asian Scottish or Asian British (e.g. Pakistani, Indian, Bangladeshi, Chinese)**
□ Any mixed or multiple ethnic groups	□ Give details ... .
D African, Caribbean or Black	**E Other ethnic group**
□ Give details	□ Give details .....

□ If you do not wish to give this information, please tick here

CARER DETAILS - Do you look after any relatives not living with you Yes / No

Please complete if you are a carer, "young carer" or have a carer

A carer is someone who looks after a relative or friend who needs support because of age, physical or learning disability or illness including mental illness

Carers:

For whom do you care (their full name)? .....
Their address (if different from your own) .....
..... Tel No. .....
Relationship to you: ..... Their GP .....

If you are cared for:

What is the name of your carer (their full name)? .....
Their address (if different from your own) .....
..... Tel No. .....
Relationship to you: ..... Their GP .....

YOUR HEALTH – ILLNESS, DISEASES, OPERATIONS

Have you ever suffered from any of the following conditions: (Please tick as appropriate)

	(approx date)		(approx date)		(approx date)
□ Asthma	.....	□ Epilepsy	.....	□ Diabetes	.....
□ Stroke	.....	□ Thyroid Problems	.....	□ Cancer	.....
□ Heart Attack	.....	□ High Blood Pressure	.....	□ Angina	.....

Please give details and approximate dates of **any other significant** illnesses, disability or operations with approximate dates:

Have your parents, brothers/sisters suffered from any of the following, or an inherited disease

Heart disease	Yes / No	Relationship to you .....
Stroke	Yes / No	Relationship to you .....
Cancer	Yes / No	Relationship to you .....
Diabetes	Yes / No	Relationship to you .....

Other (please give details below)

Medication:

Are you currently taking any tablets, medicines or injections? Yes / No
If 'YES', please give details below

Drug Name	Strength	Dose
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

Have you any allergies to medicines or to anything else? Yes / No
If 'YES', please give details

ALL PATIENTS 16 AND OVER

Height: ..... **Weight:** .....

Lifestyle (Please tick the appropriate answer)

Diet

( ) My diet is varied and balanced Yes / No
( ) I am on a special diet for medical reasons. Reason ....
( ) I am on a slimming diet ( ) I am a Vegetarian / Vegan

Smoking

( ) I have never smoked
( ) I used to smoke ..... cigarettes/ cigars ..... oz. of pipe tobacco per day but gave up in .....
( ) I currently smoke ..... cigarettes / cigars ..... oz. of pipe tobacco per day
( ) I would like advice on how to stop smoking

Drinking Note: 1 unit = ½ pint bear or lager, 1 small glass wine, 1 shot of spirit

( ) I am teetotal
( ) I only drink alcohol very occasionally on special occasions
( ) I used to drink ..... units per week but I gave up in .....
( ) I currently drink ..... units per week

Exercise

( ) Exercise physically impossible ( ) I avoid even trivial exercise
( ) I enjoy light exercise ( ) I enjoy moderate exercise
( ) I enjoy heavy exercise ( ) I am a competitive athlete

Female Patients only - (Please tick or complete / delete appropriate sections)

I currently take the contraceptive pill Yes / No Name of pill .....
I have supplies for the next: 1 month / 2 months / 3+ months
I get my supply of pills from: GP / Family Planning

I currently have a coil fitted Yes / No Date fitted .....
I currently have a contraceptive implant Yes / No Date inserted .....
I currently get Depo-provera Yes / No Next due on .....

My last Cervical smear was on ..... and taken at .....
and the result was .....

I have never had a smear .....

I was immunised against Rubella (German Measles) on ..... (Date)
I was found to be immune to Rubella by a blood test on ..... (Date)

I have had HPV vaccination: Yes / No

(Dates) 1st ..... 2nd ..... 3rd .....

I have had ..... pregnancies, resulting in: ..... Live Births
..... Still Births
..... Miscarriages

Have you had any problems during pregnancy? YES / NO
If 'YES', please give details

Patients aged up to 25 years: Measles, Mumps & Rubella Vaccination (MMR)			
Date of 1st MMR		**Date of 2nd MMR**	

IMPORTANT: FREE TEXT APPOINTMENT REMINDER SERVICE – OPT IN/OPT OUT (please indicate below:

I wish to receive FREE text appointment reminders: YES / NO Signed .....
Please remember to let us know if you change any personal details

---------- THANK YOU FOR COMPLETING THIS FORM ----------

FOR INTERNAL USE ONLY - Not previously registered with NHS – evidence seen:

EHIC Seen ..... Passport Seen .....Visa Seen .... Marriage Cert / Civil Cert / Birth Cert

Employer Letter dated ..... University Letter dated .....

International Student Course start date ..... end date .....