

## Patient's details

Please complete in **BLOCK CAPITALS** and tick  as appropriate

<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms	Surname
Date of birth	First names
NHS No.	Previous surname/s
<input type="checkbox"/> Male <input type="checkbox"/> Female	Town and country of birth
Home address	
Postcode	Telephone number

## Please help us trace your previous medical records by providing the following information

Your previous address in UK	Name of previous doctor while at that address
	Address of previous doctor

## If you are from abroad

Your first UK address where registered with a GP

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If previously resident in UK, date of leaving	Date you first came to live in UK
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## If you are returning from the Armed Forces

Address before enlisting

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Service or Personnel number	Enlistment date
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## If you are registering a child under 5

I wish the child above to be registered with the doctor named overleaf for Child Health Surveillance

## If you need your doctor to dispense medicines and appliances\*

*\*Not all doctors are authorised to dispense medicines*

- I live more than 1 mile in a straight line from the nearest chemist
- I would have serious difficulty in getting them from a chemist

Signature of Patient     
  Signature on behalf of patient     
 Date

### NHS Organ Donor registration

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death. Please tick as appropriate

- Kidneys  
  Heart  
  Liver  
  Corneas  
  Lungs  
  Pancreas  
  Any part of my body

*Signature confirming consent to organ donation*

*Date*

For more information, please ask for the leaflet on joining the NHS Organ Donor Register

### 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 3 years

*Signature confirming consent to inclusion on the NHS Blood Donor Register*

*Date*

For more information, please ask for the leaflet on joining the NHS Blood Donor Register

My preferred address for donation is: (only if different from above, e.g. your place of work)

Postcode: .....

## To be completed by the doctor

Doctors Name

HA Code

- I have accepted this patient for general medical services  
 For the provision of contraceptive services  
 I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice

Doctors Name, if different from above

HA Code

- I am on the HA CHSlist and will provide Child Health Surveillance to this patient **or**  
 I have accepted this patient on behalf of the doctor named below, who is a member of this practice and is on the HA CHS list and will provide Child Health Surveillance to this patient.

Doctors Name, if different from above

HA Code

I will dispense medicines/appliances to this patient subject to Health Authority's Approval

I am claiming rural practice payment for this patient.  
 Distance in miles between my patient's home address and my main surgery is

*I declare to the best of my belief this information is correct and I claim the appropriate payment as set out in the Statement of Fees and Allowances. An audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission.*

Authorised Signature

Name

Date

Practice Stamp

**PRE-REGISTRATION QUESTIONNAIRE**  
**STRICTLY CONFIDENTIAL**

**PLEASE NOTE: ALL NEW PATIENTS ARE REQUIRED TO ATTEND FOR A NEW PATIENT HEALTH CHECK WITHIN THE FIRST MONTH OF REGISTRATION.**

**FULL NAME:-**.....

**DATE OF BIRTH:-**..... **MALE / FEMALE**

**CURRENT ADDRESS:-**.....  
.....  
.....

**TELEPHONE NUMBER:-**.....

**PREVIOUS ADDRESS:-**.....  
.....

**MARITAL STATUS:- SINGLE / MARRIED / DIVORCED / WIDOWED / OTHER**

**NEXT OF KIN:-**.....

**PREVIOUS GP NAME/ADDRESS:-**.....  
.....

**PLEASE ANSWER THE FOLLOWING QUESTIONS IN FULL**

	<b>YES</b>	<b>NO</b>
<b>HAVE YOU EVER SUFFERED FROM:-</b>		
1 Severe headaches, blackouts, nervous/mental upset		
2 High blood pressure, heart trouble, circulatory disease		
3 Rheumatic fever		
4 Arthritis of any nature		
5 Asthma, bronchitis, emphysema or other lung disorder		
6 Recurrent indigestion, peptic ulcers of bowel disorder		
7 Diabetes, liver, kidney disorder		
8 Do you have any allergies?		
9 Have you ever suffered from depression or other mental illness		
10 Have you ever had any operations?		
11 Is there a history of Drug Abuse/Addictions/Alcoholism?		

If any of the above were answered **YES**, then please give full details below with names of conditons and appropriate dates (year will do)

.....  
.....  
.....

**LIST OF CURRENT MEDICATION**

(Please list any medications currently prescribed)

.....  
.....  
.....  
.....

**MEDICINES ALLERGIC TO**

.....  
.....

**HEIGHT:**.....  
**WEIGHT (last recorded):**.....  
**Do you smoke? YES / NO.** If so, please state how many per day.....

**FAMILY MEDICAL HISTORY**

(e.g. Cancer, Ischaemic Heart Disease, Stroke/CVA, Diabetes, Asthma)

.....  
.....  
.....

**VACCINATIONS / IMMUNISATIONS**

Please list all immunisations and dates (if known)

.....  
.....  
.....  
.....  
.....

**IDENTIFICATION OF CARERS AND CARED FOR**

Do you look after someone and are their Carer? **YES / NO**  
Does someone look after you (you have a Carer)? **YES / NO**

**DECLARATION**

*I declare that, to the best of my knowledge and belief, the statements made within this questionnaire are full, true and correct. I acknowledge that the Doctors/Nurses will base their advice and treatment on these statements.  
Failure to disclose any facts will render this application void and I understand that I will not be accepted onto the practice list.*

**Signed:**.....

**Date:**.....

## Standard Tick Box for Recording Main Language

Name.....Date of Birth.....

What is your main language? *Please select one of the languages below and tick the box. If your main language does not appear here please tick the 'Other' box and indicate your main language.*

Main Language	Tick Here
English	
Arabic	
Bengali	
Cantonese	
French	
Gaelic	
Gujarati	
Hindi	
Mandarin	
Polish	
Punjabi	
Spanish	
Turkish	
Urdu	
Welsh	
British sign language	
Patient Refused	
<ul style="list-style-type: none"> <li>Other – Please state main language</li> </ul> <p>.....</p>	

### Why does the Practice need personal information?

We need your information to:

- Create an accurate patient record for you,
- Make sure we have the right information when you call the service again,
- Help staff review the care they provide to ensure it's of the highest standard,
- Teach and train staff,

Your personal information is important because it enables us to provide the best possible service. All information is treated with the strictest confidence.

## Standard Tick Box for Recording Ethnic Group

Name..... Date of Birth.....

What is your ethnic group? *Choose ONE section from A to E and then tick the appropriate box on the right to indicate your ethnic group*

Ethnic Group	Tick Here
<b>A: White</b>	
<ul style="list-style-type: none"> <li>• British</li> </ul>	
<ul style="list-style-type: none"> <li>• Irish</li> </ul>	
<ul style="list-style-type: none"> <li>• Any other white background (please write in line below)</li> </ul>	
<b>B: Mixed</b>	
<ul style="list-style-type: none"> <li>• White and Black Caribbean</li> </ul>	
<ul style="list-style-type: none"> <li>• White and Black African</li> </ul>	
<ul style="list-style-type: none"> <li>• White and Asian</li> </ul>	
<ul style="list-style-type: none"> <li>• Any other mixed background (please write in line below)</li> </ul>	
<b>C: Asian or Asian British</b>	
<ul style="list-style-type: none"> <li>• Indian</li> </ul>	
<ul style="list-style-type: none"> <li>• Pakistani</li> </ul>	
<ul style="list-style-type: none"> <li>• Bangladeshi</li> </ul>	
<ul style="list-style-type: none"> <li>• Any other Asian background (please write in line below)</li> </ul>	
<b>D: Black or Black British</b>	
<ul style="list-style-type: none"> <li>• Caribbean</li> </ul>	
<ul style="list-style-type: none"> <li>• African</li> </ul>	
<ul style="list-style-type: none"> <li>• Any other black background (please write in line below)</li> </ul>	
<b>E: Chinese or other ethnic group</b>	
<ul style="list-style-type: none"> <li>• Chinese</li> </ul>	
<ul style="list-style-type: none"> <li>• Any other (please write in line below)</li> </ul>	
<b>Not stated/declined</b>	
<ul style="list-style-type: none"> <li>• Declined: patient chooses not to supply this information</li> </ul>	

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## Alcohol Users Disorders Identification Test (AUDIT) C

Please complete the short questionnaire before your new patient medical appointment

**Patients Name**..... **Date**.....

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink that contains alcohol?	Never	Monthly or less	2 – 4 times per month	2 – 3 times per week	4+ times per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1 - 2	3 – 4	5 – 6	7 – 9	10 +	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
<b>Total Score</b>						

If the result from this test is 5 points or more, the complete AUDIT screening tool will be completed during the new patient medical