Eric Moore Partnership Medical Practice

NEW PATIENT REGISTRATION QUESTIONNAIRE & ASSESSMENT

SECTION TO BE COMPLETED BY PATIENT			
FULL NAME		DATE OF BIRTH	
ADDRESS			
HOME PHONE №		MOBILE №	
EMAIL ADDRESS			
ETHNICITY		MAIN SPOKEN LANGUAGE	
NEXT OF KIN		EMPLOYMENT STATUS	
DO YOU HAVE A HISTORY OF MILITARY SERVICE	YES / NO	If yes, years.	

ARE YOU RECEIVING TREATMENT FOR ANY ONGOING MEDICAL CONDITIONS?	YES / NO (Please list conditions and medications prescribed) 1 2 3 4 5 6 7

IF YOU CURRENTLY RECEIVE ONGOING MEDICATION WE WILL NEED TO SEE EVIDENCE OF THIS (printed prescription from previous GP or labelled box) IN ORDER TO RE-ISSUE YOUR MEDICATION

IS THERE ANY FAMILY HISTORY OF MEDICAL CONDITIONS SUCH AS HEART, DIABETES, RESPIRATORY, STROKE OR CANCERS?	YES / NO (Please give details of condition, relationship to family member and age of relative at time of diagnosis)
DO YOU SUFFER FROM ANY ALLERGIES?	YES / NO (Please give details)

HEIGHT (approx value if unsure)		WEIGHT (approx value if unsure)	
DO YOU DRINK ALCOHOL?	YES / NO	If you do drink alcohol, please answer the questions below	
How often do you have a drink containing alcohol?			
How many units of alcohol do you drink on a typical day when drinking?			
On how many occasions have you drank 6 units (female) or 8 units (male) in the last year?			
DO YOU SMOKE TOBACCO?	YES / NO	DAILY TOBACCO USAGE	

If you currently smoke tobacco and would like to talk to someone about stopping smoking, please ask at the surgery about the free services which are available to you. If you do not wish to stop smoking please mark box ☐

WOULD YOU CLASS YOUR PHYSICAL ACTIVITY AS: (please circle)	VERY ACTIVE	MODERATE	INACTIVE
WOULD YOU CLASS YOUR DIET AS: (please circle)	GOOD	MODERATE	POOR
FEMALE PATIENTS ONLY: DATE OF LAST SMEAR TEST			
DO YOU NEED HELP IN ORDER TO CARE FOR YOURSELF?	YES / NO	Name of Carer if yes:	
DO YOU PROVIDE CARE FOR A DISABLED PERSON?	YES / NO		

By signing below I confirm that, to the best of my knowledge, the statements made on this document are true, full and correct. I acknowledge that clinicians will base their advice and treatment on these statements. I accept that non-disclosure of relevant information will render this application void and I will not be accepted onto the practice list, or will subsequently be removed from the practice list.

I understand that my registration will be cancelled immediately should the practice be notified that I should be registered to the Zero Tolerance Violent Patient Scheme, and that the Practice would not be held accountable for any delays to my medical care caused by me attempting to register at a Practice that does not provide this service

SIGNED (PATIENT)		DATE	

We use SMS services to remind patients about appointments due and booked. To opt-out please mark box ☐

OFFICIAL USE ONLY - DO NOT ENTER ANY VALUES IN THIS SECTION	
DATE MEASUREMENTS RECORDED	
BLOOD PRESSURE	
HEIGHT	
WEIGHT	