NEW PATIENT REGISTRATION QUESTIONNAIRE - OVER 15 YEARS

All information given on this form is confidential

Surname		**Forenames**	
Date of Birth		**Address**	
Tele No			
Mobile No			
Email address			
Would you be happy for us to text you regarding appointment reminders?		**Yes**	**No**
Occupation			

NEXT OF KIN			
Name		Tele No	
Relationship			
Address			
Would you be happy for us to divulge your health details to your next of kin if we need to contact them in an emergency?		**Yes**	**No**

PERSONAL MEDICAL HISTORY Do you have any ongoing health problems? Please include any diabetes/asthma/heart disease/blood pressure stroke/mental health problems/any major operations or illnesses/any current health problems: If yes, please specify	**Yes**	**No**
Do you currently take any medication? (please attach any current repeat prescription forms) Which Pharmacy would you like to collect repeat medication from?	**Yes**	**No**
Do you have any allergies? If yes, please specify		
Do you have any family history of Chronic Diseases eg Diabetes, Heart Disease? If yes, please specify		

Do you suffer from a disability?	Yes	No
Are you registered disabled?	Yes	No
If you have specific communication/information needs relating to a disability or a sensory loss then please ask at reception for a 'accessible information standard' form.		
What is your height?	What is your weight?	
Do you undertake regular exercise? (eg walking, cycling, swimming)	**Yes**	**No**

If yes, please specify			
How often do you have a drink that contains alcohol?			**Please tick**
N/A			
Never			
Monthly or less			
2-4 times a week			
4 or more times a week			
How many standard alcoholic drinks do you have on a typical day when you are drinking?			**Please tick**
N/A			
1 or 2			
3 or 4			
5 or 6			
7 or 8			
10 or more			
How often do you have 6 or more standard drinks on one occasion?			**Please tick**
N/A			
Never			
Less than monthly			
Monthly or less			
Weekly			
Daily or almost daily			
Do you smoke?	**Yes**	**No**	**Never**
If yes, how many do you smoke a day?			
If ex-smoker what date approximately did you give up?			

We offer a smoking cessation advice service at the surgery. If you would like to discuss this with a nurse please make an appointment at reception.

ETHNIC ORIGIN (please tick one)		
British/Mixed	White & Asian	Other Asian
Irish	Other Mixed	Caribbean
Other White	Indian/British	African
W&B Caribbean	Pakistani/British	Other Black
W&B African	Bangladeshi/British	Chinese
White/British		
What is your main spoken language?		

Office use only : read coded ☐