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New Patient Registration Form

Today's Date:

Please complete this confidential questionnaire (one for each member of the family to be registered with the Practice).

Please complete in BLOCK CAPITALS and tick the boxes as appropriate.

If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.

Please complete a separate form for each family member to be registered.

Full Name:					**Telephone Number:**
Mr / Mrs / Miss / Ms / Other……..					**Work Number**
Address and Postcode					**Mobile Number:**
					E-mail Address:
					Next of Kin:
					Next of Kin Contact Number:
Date of Birth:		**Previous / Mother's surname if different:**			**Town & Country of Birth**
Marital Status:		**Gender:**	**Male:**	**Female:**	**Other residents of your home:**
Occupation:					
NHS Number (If Known)					
Previous Address					**Previous Postcode:**
					Previous Doctor Telephone No.

Previous Doctor Name & Address:	If applicable, date you first came to live in Britain:

If returning from Armed Forces:	Your Service or Personnel Number	Your Enlistment Date

Your Ethnic Origin: (select one)	White (UK) 9i0	White (Irish) 9i1%	White (Other) 9i2%
Caribbean 9i3	African 9i4	Asian 9i5	Other Mixed Background 9i6%
Indian / Brit Indian 9i7	Pakistani / Brit Pakistani 9i8	Bangladeshi / Brit Bangladeshi 9i9	Other Asian Background 9iA%
Other Black Background	Chinese 9iE	Other 9iF%	Ethnic Category not stated 9iG

Your main or 1st language Spoken / Understood: (select one)	English	Hindi	Gujurati	Urdu	Bengali /Sytheti	Punjabi

Polish	Ukrainian	French	German	Spanish	Other: (Please Specify)

Smoking, Alcohol Consumption and Exercise, weight and height					
Are you currently a smoker?	Yes	No	Have you ever been a smoker?	Yes	No
If so, how many cigarettes / cigars / tobacco do you smoke in a week?			How much alcohol do you drink in a week (Units)? Please complete the AUDIT C form at the bottom of this questionnaire. (pages 4 & 5)		
If you are a smoker and want to stop, please ask for information about local smoking cessation services.					

Height (cm)		Weight (kg)	
How often do you exercise?	No. times per week	Type(s) of exercise:	

Do You Have Any Chronic Diseases /Illnesses?	Yes ☐ / No ☐	If YES, please list:					
Heart failure	☐	COPD	☐	Asthma	☐	Atrial Fibrillation	☐
Stroke	☐	Epilepsy	☐	Dementia	☐	Learning Disabilities	☐
Hypertension	☐	Cancer	☐	Depression	☐	Osteoporosis	☐
Diabetes	☐	Mental Health	☐	CKD	☐	Rheumatoid Arthritis	☐

Do you Have Any Allergies?	Yes ☐ / No ☐ If Yes Please List
1.	3.
2.	4.

Latent Tuberculosis Testing	
Are You Aged Between 16 & 35?	Yes ☐ / No ☐
Have You Been In England Less Than 5 Years?	Yes ☐ / No ☐
Date of Entry to the UK?	

Were You Born In Any Of The below Countries?				If YES, Please Tick Below	
Afghanistan		Greenland		Nepal	
Angola		Guinea		Niger	
Bangladesh		Guinea-Bissau		Nigeria	
Benin		Haiti		Pakistan	
Bhutan		India		Papua New Guinea	
Botswana		Indonesia		Philippines	
Burkina Faso		Kenya		Rwanda	
Burundi		Kiribati		Sao Tome And Principle	
Cambodia		Korea, DPR		Senegal	
Cameroon		Laos		Seychelles	
Cape Verde		Lesotho		Sierra Leone	
Central African Republic		Liberia		Somalia	
Chad		Madagascar		South Africa	
Comoros		Malawi		South Sudan	
Congo		Mali		Swaziland	
Cote d'Ivoire		Marshall Islands		Tajikistan	
Djibouti		Mauritania		Tanzania	
Democratic Republic Congo		Mauritius		Timor-Leste	
Equatorial Guinea		Micronesia		Togo	
Eritrea		Moldova		Tuvalu	
Ethiopia		Mongolia		Uganda	
Gabon		Mozambique		Vietnam	
Gambia		Myanmar		Zambia	
Ghana		Namibia		Zimbabwe	

For Office Use Only:

Latent TB Screen Needed:	Yes ☐ / No ☐

Please list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency)	**Please provide a print out of your most recent repeat prescription**
If you are a Carer, please state the name / address / phone number of the person you care for:	**Person Cared For Contact Details:**
If you have a Carer, please state their name / address / phone number and sign here if you wish us to disclose information about your health to your Carer.	**Carer Contact Details:** **Signed:** **Date:**

Women only:

When was your last smear done?	**Date**	**Was this at your GP's Surgery?**	**Yes**	**NO**
What was the result of the smear?				
Date of last mammogram (if applicable):	**Date**	**Method of contraception (if used):**		
Do you wish to see a doctor in this practice for contraceptive services (including the pill, coil or cap)?			**Yes**	**NO**

Sharing Your Medical Record

Medical Record Sharing allows your complete GP medical record to be made available to authorised healthcare professionals involved in your care. You will always be asked your permission before anybody looks at your shared medical record.

If you don't want to share your medical record tick here: ☐

Summary Care Record contains details of your key health information –medications, allergies and adverse reactions. They are accessible to authorised healthcare staff in A&E Departments throughout England. You will always be asked your permission before anybody looks at your Summary Care Record. **Are you happy to have a Summary Care Record?**	**Yes**	**No**

Your Care Connected - Your GP medical record is the most complete record of your health and wellbeing. But when you visit a hospital, access mental health or out of hours services or need an ambulance, those treating you cannot access your record. Your local NHS feel that those involved in you care should be able to see vital information about you to help improve the medical care that you receive. That is why **Your Care Connected** is being implemented across Birmingham, Sandwell and Solihull. Please see attached form to opt In or opt out.

Patient Participation Group

The Practice is committed to improving the services we provide to our patients.
To do this, it is vital that we hear from people about their experiences, views, and ideas for making services better.
By expressing your interest, you will be helping us to plan ways of involving patients that suit you.
It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice.
If you are interested in getting involved, please tick the box below and we will arrange for the Practice Patient Participation Group Application Form to be given to you at your initial consultation.

Yes, I am interested in becoming involved in the Practice Patient Participation Group (Please tick the "Yes" Box)	**Yes**

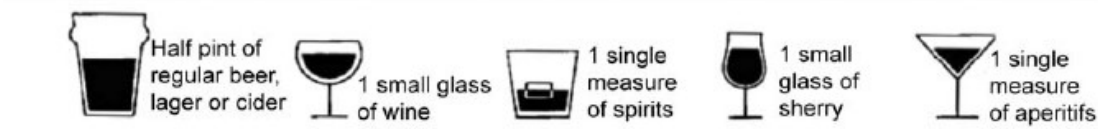
Patient Signature:		**Signature on behalf of Patient:**	

Your physical examination will include having your height, weight and blood pressure taken, and a specimen of urine for testing (it would be helpful if you would bring a specimen with you when coming to the Practice).

The Consultation will also establish relevant past medical and family history, including:

- ***Medical factors - illnesses, immunisations, allergies, hereditary factors, screening tests, current health***
- ***Social factors - employment, housing, family circumstances***
- ***Lifestyle factors - diet and exercise, smoking, alcohol and drug abuse.***

This is one unit of alcohol…



…and each of these is more than one unit

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:

- A total of 5+ indicates increasing or higher risk drinking.
- An overall total score of 5 or above is AUDIT-C positive.

If your score is above 5 please complete section 2 of this audit on the following page.

Score from AUDIT- C (previous page)

Please only complete this page if your score from the previous page was 5 or higher.

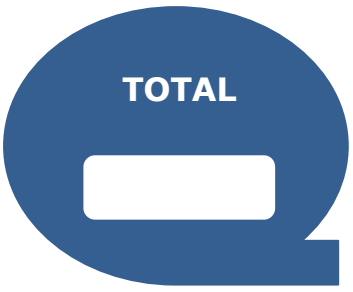
Remaining AUDIT questions

Questions	Scoring system					Your score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

- If your score is over 20, you will be referred to the specialist team for advice, please tick this box if you **do not** wish to be referred ☐

- **Scoring:** 0 – 7 Lower risk, 8 – 15 Increasing risk,
- 16 – 19 Higher risk, 20+ Possible dependence

- TOTAL Score equals
- AUDIT C Score (above) +
- Score of remaining questions



Thank you for completing this form

For more information about the services we offer, please refer to our website: www.vitalitypartnership.nhs.uk