

Pembroke Surgery

New Patient Registration Form >5yrs

<u>Today's Date:</u>

Please complete this confidential questionnaire.
Please complete a separate form for each family member to be registered.
Please complete in BLOCK CAPITALS and tick the boxes as appropriate.

Full Name:		Date of Birth:	
Mr / Mrs / Miss / Ms / Other.....		Home Number	
Address and Postcode		Mobile Number:	
		Work Number:	
Email Address:		Occupation:	
Marital Status:		Gender:	Male: <input type="checkbox"/> Female: <input type="checkbox"/>

Your height:	Feet / inches	cm	Your weight:	Stones / lbs.	kg	
Your Religion:	C of E	Catholic	Other Christian (state)	Buddhist	Hindu	Muslim
	Sikh	Jewish	Jehovah's Witness	No religion	Other religion (state)	

Your Ethnic Origin: (select one)	White British	White Irish	White Other	
	Black Caribbean	Black African	Mixed White/Caribbean	Mixed White/Asian
	Indian	Pakistani	Bangladeshi	Other Asian Background
	Other Black Background	Chinese	Mixed White/Black African	Other Ethnic Group (state)

Your main or 1st language Spoken / Understood: (select one)		English	Hindi	Gujurati	Urdu	Bengali	Punjabi
Polish	Ukrainian	French	German	Spanish	Other: (Please Specify)		

Smoking, Alcohol Consumption and Exercise:					
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?					

If you are a smoker and want to stop, please make an appointment with one of our Health Care Assistants.

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 units of alcohol do you have on a typical day when you are drinking? *	1-2	3-4	5-6	7-8	10+
How often have you had 8 or more units, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

*Units =
 Pint of 3.5-4% beer/lager = 2 units
 Pint of 5.2% beer/lager = 3 units
 Small 12% (175ml) glass of wine = 2 units
 Large 12% (250ml) glass of wine = 3 units
 Small 25 ml spirits = 1 unit (some pubs sell 35ml spirits = 1.5 units)
 Alcopops 5% = 1.4 units

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

Your Medical Background:			
What illnesses have you had & When?			
What operations have you had and When?			
Do you have any medical problems at present?			
Please list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency)			
Are there any serious diseases that affect your Parents, Brothers or Sisters (tick all that apply)	Diabetes	Heart Attack	Heart attack under age of 60
	Breast Cancer		Asthma
	Thyroid Disorder	Any other important Family Illness?	
<p><u>Patient Participation Group</u></p> <p>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.</p> <p>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.</p> <p>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.</p>			
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:	

Specific Needs:		
Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:		
Please state any Sensory Impairment you have (I.e. Speech, Hearing, Sight):		
Are you an 'Assistance Dog' User?		
Please state any Physical disabilities you have:		
Please state any Mental disabilities you have:		
Please state any requirements you have to be able to access the Practice premises		
Please state any Religious or Cultural needs:		
Do you require the help of a Translator / Interpreter?		
Please state any specific nutritional requirements you have:		
Please state any allergies and sensitivities you have:		
Please state any phobias you have:		
If you are a Carer, please state the name / address / phone number of the person you care for:	<u>Person Cared For Contact Details:</u>	
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.	<u>Carer Contact Details:</u>	
	<u>Signed:</u>	<u>Date:</u>
Do you have a "Living Will" (a statement explaining what medical treatment you would not want in the future)?	Yes / No	<i>If "Yes", can you please bring a written copy of it in to the Surgery</i>
Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)?	Yes / No	<i>If "Yes", can you please bring a written copy of it in to the Surgery please state their name / address / phone number:</i>

**THIS FORM IS TO IDENTIFY IF YOUR CHILD REQUIRES IMMUNISATION
AGAINST TUBERCULOSIS (BCG)**

One form to be completed for every child/young person please. To be completed for all young persons aged under 16 years who are registering.

This information WILL NOT be used for any other purpose.

Has your child been immunised against Tuberculosis (BCG)? Please tick ✓ Yes No

If **YES** please give the date of immunisation

Was the child born in the UK? ✓ Yes No
If **NO** please **PRINT** the country where the child was born

.....

Were either of the child's parents born outside the UK? Please tick ✓ Yes No

If **YES** please **PRINT** which country the parent/s was/were born in

.....

Were any of the child's grandparents born outside the UK? Please tick ✓ Yes No

If **YES** please **PRINT** which country they were born in

.....

Has there been a case of TB in the family in the last 5 years ? Please tick ✓ Yes No

If **YES** please confirm if your child was tested for TB at that time Yes No

.....

Next Of Kin

In order to update your personal details it would be helpful if you gave us details of your next of kin. It is important that we have these details in case there is an emergency and you or your next of kin need to be contacted.

To Pembroke Surgery Staff:

My name is: _____

My date of birth is: _____

My address is: _____

My telephone number is: _____

My **next of kin** is: _____
Please inform him/her if I have been in an accident or am admitted to hospital.

Their relation to you: _____

Landline: _____

Mobile number: _____

Address: _____

The person named above is the person that I am closest to. I consent that you discuss my condition with them. If your circumstances change please inform us as soon as possible.

If you have **no next of kin** please tick here

Signature: _____

Date: _____