NEW PATIENT APPLICATION FORM FOR ALL PATIENTS

PLEASE COMPLETE THIS APPLICATION FORM IN FULL AND RETURN IT IN PERSON WITH **PHOTO ID** and **CURRENT PROOF OF ADDRESS**

(Dated within the last month)

**PERSONAL DETAILS**

Full name: ………………………………………….. Date of Birth: …………………

Home tel. no.……………………………….. Mobile tel. no.………………………………...

**(If patient is 16-18 please state if this is own mobile or parents)**

Email address………………………………………………………………………………….

**(All patients aged 16 and over MUST have their own e-mail address for online booking purposes)**

Opt in for onlineservices Opt out for onlineservices

Occupation (Adults)…………………………………………………………………….

School attended (under 18’s)……………………………………………………………….

**What is your main language**? (If not English)……………………………………………

Do you need an interpreter? *YES/NO*

**CARERS**

Are you a carer for an elderly or disabled person?........................................

Does the person you care for live at your home? *YES/NO*

If yes, please give details of the person you are caring for

Name……………………………………………………………………………..

Relationship…………….………………………………………………………

Medical condition………………………………………………………………

REPEAT MEDICATION

Please list all the medication you currently take including dose & strength or provide a copy of your current repeat medication sheet

…………………………………………… ……………………………………………

…………………………………………… ……………………………………………

…………………………………………… ……………………………………………

…………………………………………… ……………………………………………

MEDICAL HISTORY

Do you have any of the following? (Please tick and include details)

ALLERGIES ………………………………………………………………..

MEDICATION ALLERGIES …………………………………………………………………

ASHTMA …………………………………………………………………

DIABETES …………………………………………………………………

SERIOUS ILLNESS …………………………………………………………………

Are you receiving any ongoing medical treatment? YES/NO

If yes, give details of condition treated ………………….........................................................

Are you currently under the care of a Hospital? YES/NO

If yes, please indicate which Hospital and Department/Consultant

……………………………………………………………………………………………………………………………………………………………………………………………………………………

FAMILY HISTORY

Has any close family had any of the following (please specify family member):

Diabetes………………………………… Asthma………………………………………..

Heart Disease………………………….. High Blood Pressure……………………….

Stroke…………………………………… Tuberculosis…………………………………

Eczema…………………………………. Migraine……………………………………….

Cancer (please specify type)………………………………………………………………………

LIFESTYLE

Alcohol – how many units of alcohol do you drink each week?

1unit = 1 glass wine, ½ pint of beer or single measure of spirit

Units a week………….. Never drink Alcohol…………

Smoking - Do you smoke? Yes / Ex-smoker / Never smoked

If yes, what do you smoke? Cigarettes / Cigars/ Pipe/ Vape

If yes, How many per day? .............................................

Exercise - Do you take regular exercise? None/gentle/moderate/vigorous

Diet - What type of diet do you have? (E.g. vegetarian, mixed, low fat, gluten free)

………………………………………………………………………………………………..

What is your approximate Height? ……………………. Weight? ………………….

IMMUNISATIONS (please give the date of last vaccinations)

Tetanus…………………… Polio…………………… BCG……………………..

Any other (including travel vaccinations) ……………………………………………………...

………………………………………………………………………………………………..

………………………………………………………………………………………………..

………………………………………………………………………………………………..

***Female patients only***

Current method of contraception…………………………………………………………………

Date of last smear………………………………… Result….................................................

Have you ever had an abnormal smear YES/NO

Are you taking HRT?............................................................................................................

(please specify type, dose and starting date)

Have you had a mammogram?..............................................Result……………………………….

**FAST QUESTIONNAIRE**

**For the following questions please tick the answer which best applies:**

**1 drink = 1/2 pint of beer or 1 glass of wine or 1 single spirits**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| MEN: How often do you have EIGHT or more drinks on one occasion?  WOMEN: How often do you have SIX or more drinks on one occasion? | **Never**  **0** | **Less than monthly**  **1** | | **Monthly**  **2** | **Weekly**  **3** | **Daily or almost daily**  **4** | | |
| How often during the last year have you been unable to remember what happened the night before because you had been drinking? | **Never**  **0** | **Less than monthly**  **1** | | **Monthly**  **2** | **Weekly**  **3** | **Daily or almost daily**  **4** | | |
| How often during the last year have you failed to do what was normally expected of you because of drinking? | **Never**  **0** | **Less than monthly**  **1** | | **Monthly**  **2** | **Weekly**  **3** | **Daily or almost daily**  **4** | | |
| In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down? | **No**  **0** | **Yes, on one occasion**  **2** | | **Yes, on more than one occasion**  **4** |  |  | | |
| **Total:** | | | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |  |

HOW WOULD YOU DESCRIBE YOUR ETHNIC GROUP?

***Please tick the box appropriate to yourself***

|  |  |  |
| --- | --- | --- |
| **WHITE** | British (9i0) |  |
|  | Irish (9i1) |  |
|  | Any other White background (9i2) |  |
| **MIXED** | White & Black Caribbean (9i3) |  |
|  | White & Black African (9i4) |  |
|  | White & Asian (9i5) |  |
|  | Any other mixed background (9i6) |  |
| **ASIAN OR ASIAN BRITISH** | Indian (9i7) |  |
|  | Pakistani (9i8) |  |
|  | Bangladeshi (9i9) |  |
|  | Any other Asian background (9iA) |  |
| **BLACK & BLACK BRITISH** | Caribbean (9iB) |  |
|  | African (9iC) |  |
|  | Any other Black background (9iD) |  |
| **OTHER ETHNIC CATEGORIES** | Chinese (9iE) |  |
|  | Any other ethnic category (9iF) |  |
| **NOT STATED** | Not Stated (9iG) |  |

**Signed…………………………………. Date…………………….**

**FOR SURGERY STAFF USE ONLY**

Proof of address:

**(Please put type of POA seen - must be dated within last 1 month - DO NOT photocopy)**

………………………………………………………………………………………………

Type of Photo ID taken (please photocopy)…………………………………………….

Application form checked by……………………………………………………………..

Surgery Registering at……………………………………………………………………..

Completed Registration forms checked by………………………………………………

New Patient Medical date…………………………………………………………………

**Updated 08.02.2022**