# New Patient Registration Questionnaire Form

**Please post or hand in to your chosen surgery**

**Please do not email or fax this document.**

## Patient Details

Title Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other…….. First Name

Surname Date of Birth

Home Tel. No. Yes ☐ No ☐ Preferred ☐

Mobile Tel. No. Yes ☐ No ☐ Preferred ☐

Can we contact you on these numbers & which is your preferred contact no.?

Email Consent to contacting you by email? Yes ☐ No ☐

Would you like to register for SystmOne Online, allowing you to book appointments online? Yes ☐ No ☐ * Photo ID Required.

Do you consent to receiving text message appointment reminders on your mobile phone? Yes ☐ No ☐ * Mobile Number Required

Do you have a preference of GP* you wish to register with?

*It may not always be possible to provide appointments with this GP and you will be offered an appointment with an alternative GP.

## Ethnicity and Residency

Following the recommendations of the Commission for Racial Equality and the Race Relations Act, please indicate your ethnic origin and main spoken language. - Please tick the most appropriate or complete other if necessary.

A White ☐ British ☐ Irish ☐ Other:

B Mixed ☐ White & Black Caribbean ☐ White & Black African ☐ White & Asian ☐ Other:

C Asian or Asian British ☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Other:

D Black or Black British ☐ Caribbean ☐ African ☐ White & Asian ☐ Other:

E Chinese or other Ethnic Group ☐ Chinese ☐ Other: ☐ I do not wish to specify my ethnic origin.

Please specify your main spoken language

Do you speak English? YES ☐ NO ☐

If you originally came from abroad, when did you arrive in the UK? ...

Have you ever been a member of the HM Armed forces? YES ☐ NO ☐

## Your Health and Your Family History

| | You (tick if yes) | Your Family (details) | If yes, what age? |
|---|---|---|---|
| Asthma | | | |
| Stroke | | | |
| Heart Disease | | | |
| Diabetes | | | |
| COPD | | | |
| High Blood Pressure | | | |
| Cancer | | | |
| High Cholesterol | | | |

Do you have any known allergies? ……..

Do you consider yourself to have a disability? ……..

Continued overleaf

## Lifestyle

Are you a Smoker? ☐ No, never

☐ Ex-Smoker When did you quit? ……..

☐ Yes, how many per day?..... Would you like a referral to Quit Smoking? Yes ☐ No ☐

## Next of Kin

Next of Kin (optional) _____ Relationship to you _____

Next of Kin Address _____

_____ Contact Tel. No. _____

## Medical Record Sharing and your Options

Have you received a copy of our leaflet about 'Record Sharing'? Yes ☐ No ☐

## Alcohol Assessment

| Questions in relation to the past year | Please circle your answer | | | | |
|---|---|---|---|---|---|
| How often do you have an alcoholic drink? | Never | Monthly or less | 2 - 4 times per month | 2 - 3 times per week | 4 or more 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 - 8 | 10 or more |
| How often do you have 6 or more units on a single occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| How often 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 have you failed to do what was normally expected of you because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| How often have you needed an alcoholic drink in the morning, after drinking the night before? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| How often have you felt guilty after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| How often have you been unable to remember what happened the night before as a result of drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| Have you or anybody else been injured as a result of you drinking? | No | | Yes, but not in the last year | | Yes, during the last year |
| Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down? | No | | Yes, but not in the last year | | Yes, during the last year |

Are you a Carer? YES/NO

## Patient Declaration

To the best of my knowledge, all the preceding answers and information provided are true and correct.

Signature SIGNATURE REQUIRED

Print Name _____ Date _____

Please hand in or post your form to your chosen surgery:

Derby Road Health Centre
336 Derby Road, Lenton,
Nottingham NG7 2DW

Grange Farm Medical Centre
17a Tremayne Road, Bilborough,
Nottingham NG8 4GQ

How did you hear about us?

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All information is kept completely confidential. Thank you for completing our questionnaire.