WOODFIELD ROAD SURGERY New Patient Registration Form (Adult: 16 and over)

Instructions for completing this form

1. Complete a separate form for each family member to be registered
2. Complete in BLOCK CAPITALS and tick the boxes as appropriate

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Full Name:				**Date of Birth:**
Title : ☐ **Mr**	☐ **Mrs**	☐ **Miss**	☐ **Ms**	**Gender:** ☐ **Male** ☐ **Female** ☐ **Other.** *Please state* **:**
Other. *Please state* **:**				**Marital Status:**
Mobile tel. number: We will use this to send appointment reminders and health promotion details. Please tick here to give your consent for this: ☐				**Maiden name / Mothers name if different:**
Work tel. number:				**E-mail address:**
Next of Kin: **Relationship to Patient:**				**Next of Kin contact tel. number:**

How would you prefer us to contact you:

☐ **Letter** ☐ **Email** ☐ **SMS (text)** ☐ **Phone**

Town* and Country of birth **(*If town is London please state which Borough)**	**Country:** **Town:**	**Borough (*If born in London):**

Please list other residents of your home who are registered with us:	**Name:**	**Date of Birth:**

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Looking After A Family Member

Are you looking after someone? Let us know if you are looking after someone who is ill, frail, disabled or has mental health and/or emotional support needs, or substance misuse problems.	☐ Yes ☐ No
Is someone looking after you? Let us know if a family member, friend or neighbour looks after you. If yes, they are your carer. You are welcome to invite your carer to accompany you to visits at the practice.	☐ Yes ☐ No

Carer's name :	**Relationship to you:**
Address of carer :	
Telephone number of carer :	

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Are You Currently Employed?

	If so please specify whether :	☐ **Full-time**	☐ **Part-time**	☐ **Self-employed**
	If you are not employed, please indicate which best describes you:			
	☐ **Retired**	☐ **Student**	☐ **Housewife/ Homemaker/House husband**	☐ **Unemployed**
	☐ **Other *Please state*:**			
	If returning from the Armed Forces please state which below: ☐ **Army** ☐ **Royal Navy** ☐ **Royal Air force**	**Comments:**		

4	**Your Religion** (please state)**:** It's important to let us know if your religion will affect any treatment you receive			
	Your Ethnic Origin (Please tick one)			
	☐ Black Caribbean/British	☐ Indian / British Indian	☐ Arabic	☐ White (UK)
	☐ Black African /British	☐ Pakistani / British Pakistani	☐ Chinese	☐ White (Irish)
	☐ Other Black Background	☐ Bangladeshi / British Bangladeshi	☐ Other	☐ White (Other)
	☐ Other Mixed Background	☐ Other Asian Background		☐ Ethnic Category Refused
	Do you need an Interpreter? ☐ Yes ☐ No	**If yes**, which language:		
	Do you need help with mobility/hearing/speaking? (tick all that apply)			
	☐ Wheelchair	☐ Walking aid	☐ Hearing aid	☐ British sign language (BSL) ☐ Makaton sign language
	☐ Lip reading	☐ Large print	☐ Braille	☐ Other, Please state:
	Are you currently?	☐ Homeless	☐ A Refugee	☐ An Asylum Seeker
	Are you an 'Assistance Dog' User?	☐ Yes ☐ No		
	Are you housebound?	☐ Yes ☐ No		

5	**Lifestyle**					
	Are you currently a smoker? ☐ Yes ☐ No **Have you ever been a smoker?** ☐ Yes ☐ No	If you smoke, how many Cigarettes / Cigars / Tobacco do you smoke in a day?				
	If you are a smoker and want to STOP please tick here: ☐					
	Alcohol:	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+ if male, on a single occasion in the last year?	Never	Less Than Monthly	Monthly	Weekly	Daily Or Almost Daily
	Alcohol Units: 1 Pint Of Premium Beer = 2.5 Units. 1 Pint Beer/Cider = 2 Units. Single Measure Of Spirit = 1 Unit. Small (125ml) Glass Of Wine = 1 Unit				**Total Score**	

6	**Diet and Exercise**	**What type of diet do you have?**

How much exercise do you do?		☐ Healthy
☐ Sedentary (No exercise)		☐ Unhealthy
☐ Gentle (climbs stairs, walking , gardening)		☐ Vegan
☐ Moderate (Cycling, swimming regularly)		☐ Vegetarian
☐ Vigorous (Attends gym regularly)		☐ Moderate

Please enter your height in		Please enter your weight in	
Feet / inches:	**cm:**	**Kilos/grams:**	**Stones / lbs:**

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Women Only	What is the date of your last ***Smear test***?	Date:	Result:
Was this at your GP Surgery?	☐ Yes ☐ No	Date of last ***Mammogram*** (if applicable):	
Number of ***pregnancies*** (include miscarriages & terminations) (If applicable)			
Do you wish to see a doctor in this Practice for contraceptive services (including the pill, coil or cap)?			☐ Yes ☐ No

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Your Medical Background

Are there any serious diseases that affect your parents, brothers or sisters?
Tick all that apply *and* state family member:

☐ **Diabetes** Who:	☐ **Asthma** Who:	☐ **Thyroid disorder** Who:	☐ **Stroke** Who:	☐ **COPD** Who:
☐ **Heart Attack under age of 60** Who:	☐ **Cancer (Specify type)** Who:	☐ **High Blood pressure** Who:	**Any other important family illness. *Please state*:**	Who:

Please state any allergies and sensitivities you have to medicines, food & dressings:	
Please state any mental disabilities you have:	

Are you able to administer your own medicines?	☐ Yes ☐ No	***If no*** please give details, e.g. swallowing or opening containers:

What long term medical conditions have you had?	Date of Diagnosis:
What operations or serious injuries have you had?	Date of operations or injuries:

Please list any tablets, medicines or other treatments you are currently taking / undertaking:

We can now send your prescriptions electronically to the pharmacy of your choice. If you would like us to do this, please give the name and location of the pharmacy here:

9 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 GP 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.

If you don't want to have a Summary Care Record tick here: ☐

The Care.data Programme Collates information about you and the care you receive. It links information from all the different places where you receive care, such as your GP, hospital and community services, to help them provide a full picture of your medical needs and the care you are receiving. This data is made available to NHS Commissioners so that they can design integrated services and is shared with third parties for research purposes.

I wish to OPT OUT from my Personal Confidential Data being shared outside my *GP practice*: ☐

I wish to OPT OUT from my Personal Confidential Data being shared with *third parties*: ☐

10 Patient Participation Group (PPG)

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 in the PPG, please tick yes in the box below and we will contact you with further details.

Yes I am interested in becoming involved in the PPG ☐	***No*** I am not interested in becoming involved in the PPG ☐

11 Online Services

You can now do the following online or via the SystmOnline app:

- Book and cancel appointments, order repeat prescriptions, view a summary of your medical record.

IT WILL BE YOUR RESPONSIBILITY TO KEEP YOUR LOGIN DETAILS AND PASSWORD SAFE AND SECURE. IF YOU KNOW OR SUSPECT THAT YOUR RECORD HAS BEEN ACCESSED BY SOMEONE THAT YOU HAVE NOT AGREED SHOULD SEE IT, THEN YOU SHOULD CHANGE YOUR PASSWORD IMMEDIATELY.

Yes I'd like to register for online services ☐	***No*** I don't want to register for online services ☐

12 Other Information

Do you have a "***Living Will***"? (A statement explaining what medical treatment you would not want in the future)?	☐Yes ☐No	***If "Yes",*** can you please bring a written copy of it to your first appointment?
Have you nominated someone to speak on your behalf (***e.g. a person who has Power of Attorney***)? ☐Yes ☐No	***If "Yes", please state*** their Name: Address: Phone number:	

13 Signature

Patient signature:	Signature on behalf of patient:

Thank you for completing this form. ***For more information about the services we offer, please refer to our practice leaflet or see our website: http://practice website address.***