*Woodfield Road Surgery*

## New Patient Registration Form (Adult: 16 and over)

| Today's Date |
|---|
| |

**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

**1**

| | |
|---|---|
| **Full Name:** | **Telephone Number:** |
| **Title:** Mr ☐ Mrs ☐ Miss ☐ Ms ☐ | **Work tel. number:** |
| **Other.** *Please state*: | **Mobile tel. number:** We will use this to send appointment reminders and health promotion details. Please tick here if you do not wish to receive text messages from us: ☐ |
| **Address:** | **Next of Kin:**<br>**Relationship to Patient:** |
| **Postcode:** | **Next of Kin contact tel. number:** |
| **E-mail address:** | **Maiden name / Mothers name if different:** |
| | **Marital Status:** |
| **How would you prefer us to contact you:**<br>Letter ☐ Email ☐<br>SMS (text) ☐ Phone ☐ | **Date of Birth:** / **Gender:** Male ☐ Female ☐ Indeterminate ☐ |

**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:** |
|---|---|---|
| | | |

**2**

### Looking After A Family Member

| | |
|---|---|
| **Are you looking after someone?**<br>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?**<br>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 **:**

| 3 | **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:**<br>• **Army** ☐<br>• **Royal Navy** ☐<br>• **Royal Air force** ☐ | | **Comments:** | |

| 4 | **Your Religion** (Please tick) | | | | | |
|---|---|---|---|---|---|---|
| | C of E ☐ | Catholic ☐ | Other Christian (state): ☐ | Buddhist ☐ | Hindu ☐ | Muslim ☐ |
| | Sikh ☐ | Jewish ☐ | Jehovah's Witness ☐ | No religion ☐ | Other religion (state) ☐ | |
| a | **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: ☐ | | |
| b | **Main Spoken Language?** | | **Do you need an interpreter?** Yes ☐ No ☐ | | | |
| c | **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***: ☐ | | |
| d | **Are you currently?** | Homeless ☐ | A Refugee ☐ | An Asylum Seeker ☐ | | |
| | **Are you an 'Assistance Dog' User?** | Yes ☐ | No ☐ | | | |
| | **Are you housebound?** | Yes ☐ | No ☐ | | | |

| 5 | **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 ☐ |

| 6 | **Your Medical Background** | | | | |
|---|---|---|---|---|---|
| | Are there any serious diseases that affect your parents, brothers or sisters?<br>Tick all that apply *and* state family member: | | | | |
| | Diabetes ☐<br>Who: | Asthma ☐<br>Who: | Thyroid disorder ☐<br>Who: | Stroke ☐<br>Who: | COPD ☐<br>Who: |
| | Heart Attack ☐<br>under age of 60<br>Who: | Cancer (Specify type) ☐<br>Who: | High Blood pressure ☐<br>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 chronic medical conditions have you had? | | | | Date of Diagnosis: |
| | What operations have you had? | | | | Date of operation/s: |
| | What injuries have you had? | | | | Date of injury/s |
| | Please list any tablets, medicines or other treatments you are currently taking / undertaking: | | | | |

| 7 | **Lifestyle** | | |
|---|---|---|---|
| | **Are you currently a smoker?** ☐ Yes ☐ No<br>**Have you ever been a smoker?** ☐ Yes ☐ No | | If you smoke, how many Cigarettes / Cigars / Tobacco do you smoke in a week? |
| | **If you are a smoker and want to STOP please tick here:** ☐ | | |

| **Alcohol:** | Scoring System 0 | 1 | 2 | 3 | 4 | **Your Score** |
|---|---|---|---|---|---|---|
| **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** | |

| 8 | **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:** |

## 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 arrange for the Practice 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 PPG ☐ | ***No*** I am not interested in becoming involved in the PPG ☐ |
|---|---|

## 11 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***)?<br>Yes ☐ No ☐ | ***If "Yes", please state*** their<br>Name:<br>Address:<br>Phone number: | |

## 12 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://www.woodfieldroadsurgery.co.uk/***