NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE

Please assist us by completing the following when registering and bring both this and the registration form to the surgery as soon as possible, also please book a new patients health check with one of our health care assistant.

Due to the new General Data Protection Guidelines, children aged 13 and over are able to complete the Questionnaire.

If you are the Parent/ Carer completing on behalf of your child aged 13 years and above please could both parent/carer and child print name and sign below.

(NB all information supplied will be recorded in your confidential medical records)

Parent / Carer

Print Name: …….. Sign ……

Child

Print Name: ……. Sign …….

(

Title: ……Forename(s): ……

Surname ……..NHS number (if known):.....

Date of Birth: ...../……/…… Marital status: ……..

Address:

……

……Postcode: ....……..….

Home tel: …… Mobile (if aged 16 and over): …….

Ethnicity: ……

Gender: …….

Language preference ……

Consent

Do you consent to the practice contacting you by text message for appointment reminders, invitations to health checks, vaccination reminders, to let you know that your prescription or your sick note is ready for collection and anything else relevant to your healthcare?

***Yes/No (please delete as appropriate)** **Surgery Code 9Ndp / 9NdQ**

Do you consent for us to correspond with you via email if so please supply us with a preferred e-mail address for this purpose?

***Yes/No (please delete as appropriate)** **Surgery Code 9Nds / 9Ndy**

Email address: ……

Smoking

Do you smoke? *Yes* / *No* Do you vape? *Yes* / *No*

Have you smoked in the past? *Yes* / *No*

Alcohol

For the following questions please answer to the best of your knowledge: We have provided a basic guide to alcohol content below to assist your completion:

A 750ml bottle of wine contains 10 units
A standard (175ml) glass of wine contains 2 units
A single small shot of spirits (25ml) contains 1 unit
A standard 70cl bottle of spirits contains 28 units
A pint of 3.6% strength lager/beer/cider contains 2 units
A pint of 5.2% strength lager/beer/cider contains 3 units

How many units of alcohol do you drink daily? ……

Please tell us your most recent measurements for the following (if known)

Height: ……..

Weight: …….

***Please note, we may contact you to offer support or advice if appropriate based on your submission*.**

NB: The following information you supply may assist us to provide good care for you whilst we wait for your previous medical records.

Family History

Is there any of the following in your family *(father, mother, brother, sister)* before the age of 65?

Heart Disease? *Yes* / *No* which family member? …….
Stroke? *Yes* / *No* which family member? …….
Cancer? *Yes* / *No* which family member? …….
Site of cancer? …….

Vaccinations

Are you up to date with all routine childhood immunisations? **Yes / No**
(If possible please provide the surgery with a list of your up-to-date vaccinations).

Surgical operations / serious accidents or injuries

If you have ever had any surgical operations or serious accidents or injuries then please list them below with a date if known:

Long term conditions

Do **YOU** suffer from any of the following?

- Diabetes yes / no date diagnosed …..
- High Blood Pressure yes / no date diagnosed …..
- Asthma yes / no date diagnosed …..
- COPD yes / no date diagnosed …..
- High cholesterol yes / no date diagnosed …..
- Cancer – what type? …… yes / no date diagnosed …..
- Angina yes / no date diagnosed …..
- Heart attack yes / no date diagnosed …..
- Heart failure yes / no date diagnosed …..
- Rheumatoid Arthritis yes / no date diagnosed …..
- Osteoporosis yes / no date diagnosed …..
- Epilepsy yes / no date diagnosed …..
- Depression yes / no date diagnosed …..
- Anxiety yes / no date diagnosed …..
- Dementia yes / no date diagnosed …..
- Other Mental Illness yes / no date diagnosed …..
- Stroke yes / no date diagnosed …..
- Atrial Fibrillation yes / no date diagnosed …..
- Kidney disease yes / no date diagnosed …..
- Thyroid – under of over active yes / no date diagnosed …..

Women only

Have you ever had a smear test? Yes / No
Please give date of last smear test ……

Carers in Practice

A Carer is someone who looks after a relative, neighbour or friend who cannot manage on their own. If you are a carer then please answer the following.

- Who do you care for? ……
- What is their relationship to you? ……
- Would you like to be registered as a Carer at the practice? Yes / No
- Would you like more information about services for patients who are carers? Yes / No

Consent to Share personal Information

I give permission for Montgomery Medical Practice to speak to the person/s listed below on my behalf regarding my medical details.

Name	DoB	Next Of Kin/Carer	Relationship	Contact Number	Signature

I understand this consent will be valid until I notify you in writing otherwise
Patient Signature: _____

Date: _____

Please note: If you are naming a next of kin please inform them of their responsibilities. **Surgery code 9Nd**

New Patient Medication Questionnaire (If you are taking any medication please complete the table below)

- **Name of Patient:**
- **Date of Birth:**
- **Address:**
- **Name and address of previous GP: …….....**

Name of Drug	Tablets or medicine	Strength or dose	How many times a day?	Reason for medication	When did you start taking?

Please attach a copy of your Repeat Prescription Slip from your old doctor's surgery. We will NOT be able to issue your repeat medication without this.

Surgery Use:

Please scan completed form and give original to the dispensary for medication and allergies.

Allergies (IF ANY)

Are you allergic to any drugs/ non drugs (e.g. peanuts/wasps) or have you experienced any side effects from any drugs? Please list below:

Name of drug/non drug that caused allergy ……
Type of allergy (e.g. rash etc) ……

Name of drug/non drug that caused allergy ……
Type of allergy (e.g. rash etc) ……

Name of drug/non drug that caused allergy ……
Type of allergy (e.g. rash etc) ……

Drugs known to cause you side effects (IF ANY)

Name of drug that caused side effect …….
Type of side effect (e.g. vomiting, diarrhoea etc) ……

Name of drug that caused side effect …….
Type of side effect (e.g. vomiting, diarrhoea etc) ……

Name of drug that caused side effect …….
Type of side effect (e.g. vomiting, diarrhoea etc) ……

If you have a food intolerance please list here ……

NOTES

Please remember to keep the surgery updated with your latest details
Thank you for completing.