New Patient Registration Form

Please complete ALL of this confidential questionnaire.

Please complete in BLOCK CAPITALS and tick the boxes as appropriate.

If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.

Please complete a separate form for each family member to be registered.

<table>
<tr><td colspan="5">Full Name:</td><td colspan="2">Telephone Number:</td></tr>
<tr><td colspan="5">Mr / Mrs / Miss / Ms / Other……..</td><td colspan="2">Work Number:</td></tr>
<tr><td colspan="5" rowspan="4">Address and Postcode:</td><td colspan="2">Mobile Number:</td></tr>
<tr><td colspan="2">E-mail Address:</td></tr>
<tr><td colspan="2">Can we contact you by text? Y/N

Can we contact you by email? Y/N</td></tr>
<tr><td colspan="2">Next of Kin:</td></tr>
<tr><td colspan="5">Date of Birth:</td><td colspan="2">Next of Kin Contact Number:</td></tr>
<tr><td>Marital Status:</td><td></td><td>Gender:</td><td>Male:</td><td>Female:</td><td colspan="2">Other residents of your home:</td></tr>
<tr><td colspan="5">Occupation:</td><td colspan="2" rowspan="2">Previous Surgery:</td></tr>
<tr><td colspan="5" rowspan="4">Names and Ages of Children:</td></tr>
<tr><td colspan="2">Previous Postcode:</td></tr>
<tr><td colspan="2">Previous Doctor Telephone No.</td></tr>
<tr><td colspan="2">If applicable, date you first came to live in Britain:</td></tr>
<tr><td>Your height:</td><td>Feet / inches</td><td>cm</td><td>Your weight:</td><td>Stones / lbs.</td><td>Kg</td></tr>
<tr><td colspan="7">If you have not checked your weight in the last 3 months please ask at reception to be weighed</td></tr>
</table>

Your Religion:	C of E	Catholic	Other Christian (state)	Buddhist	Hindu	Muslim
	Sikh	Jewish	Jehovah's Witness	No religion	Other religion (state)	

Your Ethnic Origin: (select one)	White (UK)	White (Irish)	White (Other)
Caribbean	African	Asian	Other Mixed Background
Indian / Brit Indian	Pakistani / Brit Pakistani	Bangladeshi / Brit Bangladeshi	Other Asian Background
Other Black Background	Chinese	Other	Ethnic Category not stated

Your main or 1st language Spoken / Understood: (select one)		English	Hindi	Gujurati	Urdu	Bengali /Sytheti	Punjabi
Polish	Ukrainian	French	German	Spanish	BSL	Other: (Please Specify)	

Will you need help in translation during contact with us? Y / N

Smoking and Exercise:					
Are you currently a smoker?	Yes	No	Have you ever been a smoker?	Yes	No

If you are a smoker we advise you to stop, as there are many health benefits from giving up. If you would like help and information on local smoking cessation services please ask us.			
How often do you exercise?	No. times per week	Type(s) of exercise:	

Your Medical Background:	
What health problems do you have or have had in the past and when?	
What operations have you had and when?	
Do you have any medical problems at present?	
Please list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency)	
If on Warfarin, what type of regular blood test do you have? (Please tick one)	INR*/finger prick blood test ☐ ***OR*** Blood taken from a vein in your arm ☐

If you wish you can nominate a local chemist for your prescriptions to be sent to.	**Name and location of chemist:**	
Are you able to administer your own medicines?	**Yes**	**No – please detail specific issues (e.g. swallowing, opening containers)**

Are there any serious diseases that affect your parents, brothers or sisters (tick all that apply)	**Diabetes**	**Heart Attack**	**Heart attack under age of 60**	**Bowel Cancer**
	Breast Cancer		**High Blood Pressure**	**Asthma** / **Stroke**
	Thyroid Disorder		**Any other important family illness?**	

What immunisations have you had? (please tick all that apply)	**Diphtheria**	**Measles**	**German Measles**	**Tetanus**	**Polio**	**MMR**
	Whooping Cough		**Pre-school booster**	**Triple vaccine (Diphtheria, Tetanus & Pertussis) – 3 doses**		

Specific Needs:

Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:

Please state any sensory Impairment you have (i.e. speech, hearing, sight):	
Are you an 'assistance dog' user?	
Please state any physical disabilities you have:	
Please state any mental disabilities you have:	
Please state any requirements you have to be able to access the Practice premises	
Please state any religious or cultural needs:	
Do you require the help of a translator / interpreter?	
Please state any specific nutritional requirements you have:	
Please state any allergies and sensitivities you have:	
Please state any phobias you have:	
Are you a carer?	**Y/N** **Who do you care for?**

Do you have a carer? If so please state their name / address / phone number and sign here if you wish us to disclose information about your health to your carer.	**Carer contact details:** **Signed:** **Date:**

Do you have a "Living Will" (a statement explaining what medical treatment you would not want in the future)?	**Yes / No**	***If "Yes", Please bring a written copy of it into the surgery so we can add it to your medical records***
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/relationship:**

Summary Care Records

The NHS Summary Care Record is an electronic record of important information about your health.
It will be available to health care staff providing your NHS Care.

Are you happy to have a Summary Care Record?	**Yes**	**No**

When we refer you to another health professional for care, we need to give them your medical history so they are aware of your health & any medication you are taking.
If for any reason you do not want us to share your medical history, please inform the doctor at the time of referral.

Do you have online access? If so and you would like to sign up to our online booking, medication ordering and medication/allergy history PLEASE ASK AT RECEPTION. They will require photo ID and we then provide you with a username & password.

Patient Participation Group

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 keep you up to date with developments within the Practice.
If you are interested in getting involved, please provide your name, email address and contact telephone number and we will pass these details to the group coordinator.

Name:

Email address:

Telephone number:

***Alternatively, you can log onto our website at www.litchdonmedicalcentre.co.uk to join. Select the orange tab 'Join Our Patient Group' on our main homepage and follow the prompts.**

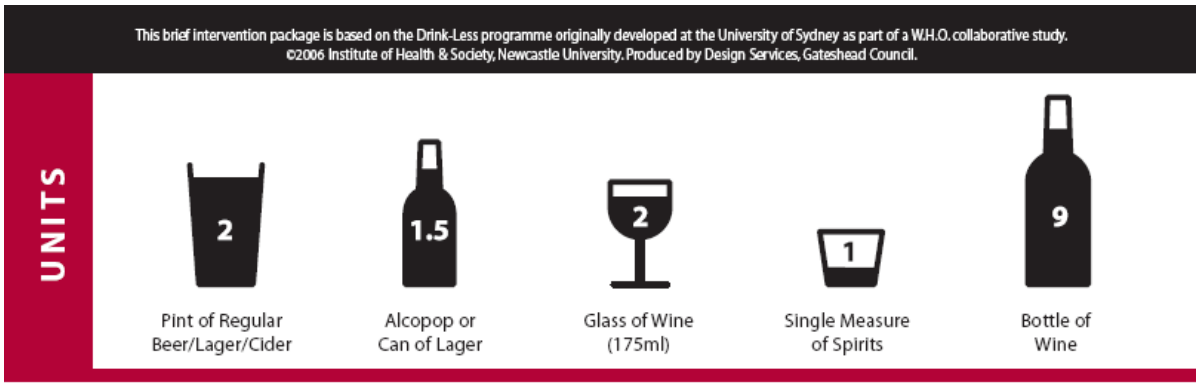
Patient signature:		**Signature on behalf of patient:**	
		Name of person signing on behalf of patient.	

For more information about the services we offer, please see our website: www.litchdonmedicalcentre.co.uk

LITCHDON MEDICAL CENTRE

Please complete this Alcohol Intake Screening questionnaire

Name: **Age:** **Date completed:**



Please follow the instructions and complete the following questionnaire:

ALCOHOL USERS DISORDERS IDENTIFICATION TEST (AUDIT) C

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink that contains alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking	1 - 2	3 – 4	5 – 6	7 – 8	10+	
How often do you have 6 or more standards drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

If your score is 5 or more, please complete the additional questionnaire on the next page.

Additional questionnaire:

Name:

Alcohol Users Disorders Identification Test (AUDIT)

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink that contains alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0-7 = sensible drinking, 8-15 = hazardous drinking, 16-19 = harmful drinking and 20+ = possible dependence

If your score on this sheet indicates hazardous or harmful drinking we would recommend you reduce your alcohol intake. If you would like help please make an appointment with the doctor or nurse.

Thank you for completing all of this questionnaire