

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:				Date of Birth:	
	Title : <input type="checkbox"/> Mr		<input type="checkbox"/> Mrs		Gender: <input type="checkbox"/> Male	
	<input type="checkbox"/> Miss		<input type="checkbox"/> Ms		<input type="checkbox"/> Female	
	Other. <i>Please state</i> :				<input type="checkbox"/> Other. <i>Please state</i> :	
	Mobile tel. number:				Marital Status:	
	We will use this to send appointment reminders and health promotion details. Please tick here to give your consent for this: <input type="checkbox"/>				Maiden name / Mothers name if different:	
	Work tel. number:				E-mail address:	
	Next of Kin:				Next of Kin contact tel. number:	
	Relationship to Patient:					
	How would you prefer us to contact you:					
<input type="checkbox"/> Letter <input type="checkbox"/> Email <input type="checkbox"/> SMS (text) <input type="checkbox"/> Phone						
Town* and Country of birth			Country:		Borough (*If born in London):	
(*If town is London please state which Borough)			Town:			
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?	
	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.	
	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	
<input type="checkbox"/> Yes <input type="checkbox"/> No		
Carer's name :	Relationship to you:	
Address of carer :		
Telephone number of carer :		

3	Are You Currently Employed?				
	If so please specify whether :		<input type="checkbox"/> Full-time	<input type="checkbox"/> Part-time	<input type="checkbox"/> Self-employed
	If you are not employed, please indicate which best describes you:				
	<input type="checkbox"/> Retired	<input type="checkbox"/> Student	<input type="checkbox"/> Housewife/ Homemaker/House husband		<input type="checkbox"/> Unemployed
	<input type="checkbox"/> Other <i>Please state:</i>				
	If returning from the Armed Forces please state which below:				Comments:
<input type="checkbox"/> Army <input type="checkbox"/> Royal Navy <input type="checkbox"/> Royal Air force					

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)			
	<input type="checkbox"/> Black Caribbean/British	<input type="checkbox"/> Indian / British Indian	<input type="checkbox"/> Arabic	<input type="checkbox"/> White (UK)
	<input type="checkbox"/> Black African /British	<input type="checkbox"/> Pakistani / British Pakistani	<input type="checkbox"/> Chinese	<input type="checkbox"/> White (Irish)
	<input type="checkbox"/> Other Black Background	<input type="checkbox"/> Bangladeshi / British Bangladeshi	<input type="checkbox"/> Other	<input type="checkbox"/> White (Other)
	<input type="checkbox"/> Other Mixed Background	<input type="checkbox"/> Other Asian Background		<input type="checkbox"/> Ethnic Category Refused
	Do you need an Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which language:			
	Do you need help with mobility/hearing/speaking? (tick all that apply)			
	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Walking aid	<input type="checkbox"/> Hearing aid	<input type="checkbox"/> British sign language (BSL)
<input type="checkbox"/> Lip reading	<input type="checkbox"/> Large print	<input type="checkbox"/> Braille	<input type="checkbox"/> Other, Please state:	
Are you currently?	<input type="checkbox"/> Homeless	<input type="checkbox"/> A Refugee	<input type="checkbox"/> An Asylum Seeker	
Are you an 'Assistance Dog' User?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you housebound?		<input type="checkbox"/> Yes <input type="checkbox"/> No		

5	Lifestyle						
	Are you currently a smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No		If you smoke, how many Cigarettes / Cigars / Tobacco do you smoke in a day?				
	Have you ever been a smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No						
	If you are a smoker and want to STOP please tick here: <input type="checkbox"/>						
	Alcohol:		Scoring System				Your Score
			0	1	2	3	
	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?		<input type="checkbox"/> Healthy	
	<input type="checkbox"/> Sedentary (No exercise)		<input type="checkbox"/> Unhealthy	
	<input type="checkbox"/> Gentle (climbs stairs, walking , gardening)		<input type="checkbox"/> Vegan	
	<input type="checkbox"/> Moderate (Cycling, swimming regularly)		<input type="checkbox"/> Vegetarian	
	<input type="checkbox"/> Vigorous (Attends gym regularly)		<input type="checkbox"/> Moderate	
	Please enter your height in		Please enter your weight in	
Feet / inches:	cm:	Kilos/grams:	Stones / lbs:	

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

8	Your Medical Background				
	Are there any serious diseases that affect your parents, brothers or sisters? Tick all that apply <u>and</u> state family member:				
	<input type="checkbox"/> Diabetes Who:	<input type="checkbox"/> Asthma Who:	<input type="checkbox"/> Thyroid disorder Who:	<input type="checkbox"/> Stroke Who:	<input type="checkbox"/> COPD Who:
	<input type="checkbox"/> Heart Attack under age of 60 Who:	<input type="checkbox"/> Cancer (Specify type) Who:	<input type="checkbox"/> High Blood pressure Who:	<input type="checkbox"/> Any other important family illness. <u>Please state:</u> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No		<u>If no</u> 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:				

