Victoria Medical Centre

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:**
Address:				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: ☐
				Next of Kin: **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: **Please tick all that apply** **Letter** ☐ **Email** ☐ **SMS (text)** ☐ **Phone** ☐				**Date of Birth:**
Gender: **Male** ☐ **Female** ☐ **Indeterminate** ☐				
Town of birth: **Country of birth:**				**If born in London which borough:**

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

2

Carers	
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 **:**	

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: • **Army** ☐ • **Royal Navy** ☐ • **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) ☐	
	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: ☐		
	Main Spoken Language?		**Do you need an interpreter?** Yes ☐	No ☐		
	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 ☐			
	Sexual orientation. Please tick which box you feel applies to you:					
	Heterosexual (straight) ☐	Lesbian (prefers women) ☐	Gay (prefers men) ☐			
	Bi-sexual (prefers men and women) ☐	Other (please state) ☐	Prefer not to say ☐			

5 **Your Medical Background**

Are there any serious diseases that affect you?

Diabetes ☐	Asthma ☐	Thyroid disorder ☐	Stroke ☐	COPD ☐
Heart Attack ☐	Cancer ☐ (please specify)	High Blood pressure ☐	Blood clots ☐	Mental health concerns ☐

Other medical conditions / problems not listed above:

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Please list and date any surgery / operations you have had?

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

What injuries have you had including dates?

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

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Are you able to administer your own medicines? Yes ☐ No ☐

If no please give details, e.g. swallowing or opening containers:

PLEASE NOMINATE A PHARMACY OF YOUR CHOICE:

6	**Family history**			
	Have you mother, father, brother or sister had any of the following medical problems?			
	Diabetes ☐	Asthma ☐	Diabetes ☐	Stroke ☐
	Heart Attack ☐	Cancer (Specify type) ☐	High Blood pressure ☐	Blood clot ☐
	Osteoporosis ☐			
	We appreciate this is a sensitive question, however it would help us to offer any support should you require. Has any member of your family committed suicide? ☐ Yes ☐ No It would be helpful for us to if you state what the relationship was with this particular family member ……			

7	**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 week?	
	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**	

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

9 Women Only

What is the date of your last ***Smear test***?		Result:	
Was this at your GP Surgery?	Yes ☐ No ☐	Date of last ***Mammogram*** (if applicable):	
Number of ***pregnancies*** (include miscarriages & terminations) (if applicable)			

What contraception are you currently using (if applicable)

Combined pill ☐	Combined patch ☐	Combined vaginal ring ☐
Progestogen pill (mini pill) ☐	Progestogen injection ☐	Progestogen implant ☐
Intra-uterine device (coil without hormones) ☐	Intra-uterine system (coil with hormones) ☐	Other (please state) ……

Please state what hormone replacement therapy you are using (if applicable)……

10 Sexual Health

Are you currently sexually active? Yes ☐ No ☐	If yes how long have you been with your current partner?
Have you ever had a sexual health screen? Yes ☐ No ☐	If yes, when was this and what was the result?
If you would like a sexual health screen please contact the surgery for further information.	

11 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*: ☐

12 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 ☐

13	**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:	

14	**Keeping in touch**
	We endeavour to keep you up to date with services offered at the surgery and also to make it easy for you get make appointments and request medication. Please state which methods you would like us to get in touch with you: Telephone ☐ Can we leave a voice message if needed Yes ☐ No ☐ Text message ☐ Email ☐ Letter ☐ We also offer online services to book appointment and to request certain medications. Please tick this box if you would like a username and password generated for this service and we will sent this via text message ☐

15	**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.victoriamedicalcentre.com/***