Registration Form

MyHealth
together, you're healthier

1 Today's date:	DD / MM / YYYY

OFFICE USE:

2 Registration Type	
➢ **I wish to register as a regular patient:** ☐ Live in practice area ☐ Live out of area (no visits)	
Select:	☐ Previously registered with the NHS (change of doctor)
	☐ Baby first registration (NHS number from maternity discharge required)
	☐ Ex services (Please give last civilian address as previous address below) Enlistment date: _____ Leaving date: _____
	☐ Returning from abroad (Please give last UK address as previous address) Leaving date:_____ Return date: _____
	☐ New from abroad (First registration and living in UK over 6 months – Proof of status required). Date of arrival in UK: _____
➢ **I wish to register as a temporary patient and I have a regular GP elsewhere in the UK:**	
Select:	☐ Short stay - Over 24 hours to under 15 days
	☐ Long stay - 15 days to 3 months
	Home GP Name/Address: _____
➢ **Immediately Necessary treatment:**	
Select:	☐ I am in the area under 24 hours and am registered with another GP
	☐ I am a visitor from the EEA or Switzerland (EHIC or passport required)
➢ **Private treatment:** ☐ I am an overseas visitor (Other than EEA or Switzerland)	
➢ **Other / Interpractice:** ☐ NHS 111 have arranged treatment; I require urgent treatment and live outside the practice area of my regular GP in England	

3 My Details			
Title:	Mr / Mrs / Miss / Ms / Dr / _____		
Surname:			
Forename(s):			
Previous Surname(s):			
Date of Birth:	DD / MM / YYYY	**Gender:**	Male / Female
Town/Country of birth:		**NHS Number:**	
Marital Status:			
Previous/Regular GP Name and Address:			

4 Local Address			
House/Street:			
Locality:			
City:		**Post Code:**	
Landline Telephone:		**Mobile Telephone:**	
We may use your mobile number for text messages, e.g. Appointment reminders and test results. ☐ Tick here if you wish to opt out of receiving text messages.			
Email address:			
Only include your email address if you are happy for us to use this to contact you. We may share this with other health providers directly involved in your care.			

5 Previous Address (Regular Registration) / Home Address (Others)			
House/Street:			
Locality:			
City:		**Post Code:**	
Country:			

6 Please sign and date below, and then return this form to reception.			
Signature of patient:		**Signature on behalf of patient under 16:**	
Date:	DD / MM / YYYY		

New Patient Questionnaire

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1	Today's date:	DD / MM / YYYY	OFFICE USE:	

2 General Information About You

Surname:		**Date of Birth:**	DD / MM / YYYY
Forename(s):			
If registering a new baby, please state mother's name:			
Ethnic origin We are obliged to inform the NHS of your ethnic background	☐ White British	☐ Black British	☐ Chinese
	☐ Mixed British	☐ Black African	☐ Asian
	☐ Nepalese	☐ Black Caribbean	☐ Mixed Asian
	☐ Polish	☐ Other (please specify): _____	
	☐ I do not wish to disclose my ethnic origin		
Main language:		**Do you require an interpreter?**	Yes / No

3 Carers

A carer is an unpaid individual who looks after a relative, friend or neighbour who needs help due to illness, disability or in need of emotional support.

Do you look after someone?	Yes / No	**If YES, who?**	Name: Tel:
Does someone look after you?	Yes / No	**If YES, who?**	Name: Tel:

4a Smoking (Children)

If registering a patient aged under 15 years old

Does anyone in the home environment smoke?	Yes / No	**If YES, who?**	

4b Smoking (Adults)

If you are aged 15 or over

Do you currently smoke?	Yes / No	**Have you previously smoked?**	Yes / No
How many per day?		**If yes, when did you stop?**	

5 Alcohol

If you are aged 15 or over

How often do you have a drink that contains alcohol?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	Over 4 times per week
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1 to 2	3 to 4	5 to 6	7 to 8	Over 9
How often do you have 6 or more standard alcoholic drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

6 Care/Nursing Home Patients

Only please complete this section if the patient resides in residential care/nursing home

Name of Home:					
Continence Urine:	Yes / No	**Comments:** (e.g. catheter or pads)			
Continence Faeces:	Yes / No	**Comments:** (e.g. pads)			
Blood Pressure:	/	**Urinalysis Protein:**	Yes / No	**Urinalysis Glucose:**	Yes / No
Weight:	Kgs	**Height:**	Metres	**BMI:**	

7 Are you currently being seen by a consultant at a hospital?

Consultant:	Speciality:	Hospital:

8 Health History

Date:	Illnesses, accidents or operations:

9 Current Medications*

* **If you are on any repeat medication you must make an appointment with a GP before your next prescription is due.**

10 Allergies

Please add known allergies to medications foods etc.

11 Screening (Female patients)

Have you ever had a cervical smear?	Yes / No	**If YES, where?**	GP / FPC / Hospital / Other
When was your last smear?		**Smear result:**	Normal / Early Recall / Colposcopy
Have you ever had breast screening?	Yes / No		

12 NHS Organ Donor Registration

If you would like to register on the NHS Organ Donor register as someone whose organs/tissue may be used for transplantation after death or if you would like to join the NHS Blood Donor Register, please visit **OrganDonation.nhs.uk** or telephone **0300 123 23 23.**

13 Thank you for completing this questionnaire.

Signed:		Date:	

Please sign and date above, and then return this form to reception.