

Hillview Medical Centre New Patient Questionnaire & Registration Form

| PERSONAL DETAILS: | |
|--|---|
| Title | |
| Surname | |
| Forename | |
| Middle Name(s) | |
| Date of Birth | |
| NHS Number | |
| Gender | |
| Marital Status | |
| Previous Surname(s) (where applicable) | |
| Town & Country of Birth | |
| Ethnicity | <input type="checkbox"/> British <input type="checkbox"/> African <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Caribbean <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Irish <input type="checkbox"/> Other White <input type="checkbox"/> Other Asian <input type="checkbox"/> Other Black <input type="checkbox"/> Other Mixed <input type="checkbox"/> White Asian <input type="checkbox"/> Pakistani <input type="checkbox"/> W&B African <input type="checkbox"/> W&B Caribbean <input type="checkbox"/> Refuse to Divulge |
| Main Language | |
| Interpreter Required? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| HOME ADDRESS: | |
| House Name\Flat Number | |
| Number & Street | |
| Locality | |
| Town | |
| County | |
| Postcode | |
| CONTACT DETAILS: | |
| Home Telephone | |
| Mobile Telephone | |
| Work Telephone | |
| Email Address | |
| PATIENT CONTACTS: | |
| Next of Kin | |
| Relationship | |
| Telephone Number | |
| PLEASE HELP US TRACE YOUR PREVIOUS MEDICAL RECORDS BY PROVIDING THE FOLLOWING: | |
| Previous address in the UK | |
| Name & Address of previous GP | |
| IF YOU ARE FROM ABROAD: | |
| Your first UK address where registered with a GP | |
| If previously resident in UK; date of leaving | |
| Date you first came to live in the UK | |
| IF YOU ARE RETURNING FROM THE ARMED FORCES: | |
| Address before enlisting | |

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| | | | | | |
| Service or Personnel number | | | | | |
| Enlistment Date | | | | | |
| Date of leaving | | | | | |
| MEDICAL HISTORY: | | | | | |
| Please list all current or past illnesses/operations including dates where possible: | | | | | |
| <input type="checkbox"/> Heart Disease / Angina | <input type="checkbox"/> Diabetes | | | | |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke/TIA | | | | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer | | | | |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Rheumatoid Arthritis | | | | |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Other (please state): | | | | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> COPD | | | | |
| | <input type="checkbox"/> Hypothyroidism | | | | |
| | <input type="checkbox"/> Dementia | | | | |
| Do you have any Allergies? (e.g. antibiotics, food, bee sting, latex,) <input type="checkbox"/> YES <input type="checkbox"/> No | | | | | |
| If Yes please state: | | | | | |
| Immunisations; If known, please circle the immunisation received and complete the date if known; | | | | | |
| | Date Received | | | | |
| Pneumococcal | Date Received | | | | |
| Tetanus | Date Received | | | | |
| Typhoid | Date Received | | | | |
| Hepatitis A | Date Received | | | | |
| Polio | Date Received | | | | |
| Yellow Fever | Date Received | | | | |
| Hepatitis B | Date Received | | | | |
| MMR | Date Received | | | | |
| Ladies: Are you currently Pregnant? <input type="checkbox"/> YES <input type="checkbox"/> No | | | | | |
| If you are pregnant please provide estimated delivery date: | | | | | |
| Have you had a smear test? If so when? | | | | | |
| Have any close relatives ever suffered from: the following, please indicate which relative:- | | | | | |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | | | | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | | | | |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Diabetes | | | | |
| <input type="checkbox"/> Cancer – type..... | <input type="checkbox"/> Other | | | | |
| Drinking: Please complete the following questions | | | | | |
| How often do you have a drink containing alcohol? | Never | Monthly or less | 2 – 3 times per month | 2 to 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 or more if male, on a single occasion in the last year? | Never | Less than Monthly | Monthly | Weekly | Daily or almost daily |
| How often during the last year have you found that you were not able to stop drinking once you had started? | Never | Less than Monthly | Monthly | Weekly | Daily or almost daily |
| How often during the last year have you failed to do what was normally expected from you because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| How often during the last year have you had a feeling of guilt or remorse after | Never | Less than monthly | Monthly | Weekly | Daily or almost |

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| drinking? | | | | | daily | |
| How often during the last year have you been unable to remember what happened the night before because you had been drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| Have you or somebody 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 or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down? | No | | Yes, but not in the last year | | Yes, during the last year | |
| CURRENT MEDICATION | | | | | | |
| If you have a repeat medication slip from your previous GP please attach to this form. | | | | | | |
| PRACTICE SERVICES\GROUPS: | | | | | | |
| Would you be interested in joining the Practice Patient Participation Group? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | |
| Carers: If you are a Carer please ask the receptionist for a yellow carers registration card so you can be added to the Practice's Register | | | | | | |
| Identifying Patients with Disabilities and other needs - Are you: | | | | | | |
| registered blind <input type="checkbox"/> partially sighted <input type="checkbox"/> registered deaf <input type="checkbox"/> registered deafblind <input type="checkbox"/> on the learning disabilities register <input type="checkbox"/> have a visual impairment <input type="checkbox"/> have hearing difficulties <input type="checkbox"/> or use a hearing aids <input type="checkbox"/> | | | | | | |
| Do you have any information or communication needs when attending the surgery or receiving calls and letters from us? | | | | | | |
| Are you happy for these requirements to be shared with other healthcare professionals? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | |
| Electronic Prescription Service: | | | | | | |
| The practice can now send your prescription to your preferred pharmacy electronically. If you have previously nominated a pharmacy in another area and you now wish to change to a local pharmacy, please inform us of your preferred pharmacy: | | | | | | |
| | | | | | | |
| Signed: _____ | | | | | | |
| Date: _____ | | | | | | |
| Should you require any further information about the Practice please refer to the Practice Website: www.hillviewmedicalcentre.com or speak to Reception. | | | | | | |
| RECEPTION ONLY: | | | | | | |
| Type of ID Seen: 1. _____ 2. _____ | | | | | | |
| Seen by: _____ | | | | | | |