Grey Gable Surgery
New Patient Registration Form

Today's Date:

Please complete this confidential questionnaire (one for each member of the family to be registered with the Practice). The information will help us to provide better and more comprehensive care for you. When you register you will be allocated a named accountable GP, although this will not restrict which GP you can see. You will also be offered a 'New Patient Appointment' with a Practice Nurse. Please bring a urine sample with you for your appointment.

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

Please bring your driving licence/passport to confirm your address and date of birth.

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

Full Name:				**Telephone Number:**
Mr / Mrs / Miss / Ms / Other……..				**Work Number**
Address and Postcode				**Mobile Number:** **(you may receive appointment invitations and reminders by text)**
				E-mail Address:
Date of Birth:	**Previous / Mother's surname if different:**			**Town & Country of Birth:**
Marital Status:		**Gender:**	**Male:** / **Female:**	**NHS Number (If Known)**
If applicable, date you first came to live in Britain:				
If returning from Armed Forces:	**Your Service or Personnel Number**			**Your Enlistment Date**
Next of Kin:				**Next of Kin Contact Number:**

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) 9i0**	**White (Irish) 9i1%**	**White (Other) 9i2%**
Caribbean 9i3	**African 9i4**	**Asian 9i5**	**Other Mixed Background 9i6%**
Indian / Brit Indian 9i7	**Pakistani / Brit Pakistani 9i8**	**Bangladeshi / Brit Bangladeshi 9i9**	**Other Asian Background 9iA%**
Other Black Background	**Chinese 9iE**	**Other 9iF%**	**Ethnic Category not stated 9iG**

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

Smoking, Alcohol Consumption and Exercise:					
Are you currently a smoker?	Yes 137R	No	If no, have you ever been a smoker?	Yes 137S	No 1371
If so, how many cigarettes / cigars / tobacco do you smoke in a week?			*If you are a smoker and want to stop, please ask for information about local smoking cessation services.*		
How often do you exercise?	No. times per week		Type(s) of exercise:		

Scoring for each question:	0	1	2	3	4	Your score
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 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					Total alcohol score:	

Please complete this page if your 'Total alcohol score' above is 5 or more.

	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 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 drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost 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	

Your Medical Background:			
Have you ever suffered from any of the following?			
Condition	**Yes**	**No**	**Approximate date started**
EPILEPSY			
BLINDNESS/GLAUCOMA			
BLOOD PRESSURE			
DIABETES			
STROKE/TIA			
HEART ATTACK			
ASTHMA			
ECZEMA			
CANCER (BREAST/ BOWEL/LUNG/OTHER)			
ALLERGIC TO PENICILLIN			
OTHER ALLERGIES			
Medications & medical devices	If you are currently taking any medications, please provide us with a copy of your **repeat prescription slip** so that we can ensure there is no interruption to your supply of medication. Please also let us know if you have a contraceptive device (eg coil or implant) fitted.		
Are you able to administer your own medicines?	**Yes/No**	**If 'No' please detail specific issues (e.g. swallowing, opening containers)**	
28 day prescribing			
Please note that our surgery has a policy of prescribing 28 days of medication (with the exception of some HRT and Contraceptive medicines). This is in line with best practice guidelines which balance patient convenience, drug wastage and patient safety.			
Please tick here to acknowledge that you have read and understood this information:			

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):		
Do you have any communication or information needs relating to a disability or sensory loss?		**If yes, please specify your required method of communication:**
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:		
If you are a Carer, please state the name / address / phone number of the person you care for:	**Person Cared For Contact Details:**	
If you have a Carer, 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", can you please bring a written copy of it to your New Patient Consultation***
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:**

Women only:				
When was your last smear done?	Date	Was this at your GP's Surgery?	Yes	NO
What was the result of the smear?				
Date of last mammogram (if applicable):	Date	Method of contraception (if used):		
Do you wish to see a doctor in this practice for contraceptive services (including the pill, coil or cap)?			Yes	NO

Summary Care Records.

The NHS are changing the way your health information is stored and managed.
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. An information pack is available.

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

The security of the information we hold about you is very important to us. Further information on how we process, store and share your data can be found in our leaflet 'How we use your information' and in our 'Data Protection Privacy Notice' available at Reception or on our website www.greygablesurgery.com

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 up to date with developments within the Practice.
If you are interested in getting involved, please tick the box below and we will arrange 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 Practice Patient Participation Group (Please tick the "Yes" Box)	Yes

Contacting you

Unless you have detailed a specific requirement based on a sensory loss or disability, we will record by default that your preferred method of communication is 'written'. This includes letters and texts but will not exclude us from contacting you by telephone where it is more appropriate to do so. Please let us know if written communication is not appropriate for your needs. Thank you.

Patient Signature:		Signature on behalf of Patient:	

New Patient Checks - Your physical examination will include having your height, weight and blood pressure taken, and a specimen of urine for testing (it would be helpful if you would bring a specimen with you when coming to the Practice).

Thank you for completing this form

For more information about the services we offer, please refer to your new patient pack or see our website: www.greygablesurgery.com