



## **NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE**

## **Dear Patient:**

To register with the practice, please complete this questionnaire as fully as possible. The information will help the doctor make an initial assessment of your health which will help in your future treatment. Patients will be asked to attend the practice for an initial consultation and some basic checks.

| NHS Number:                     | Title:         |
|---------------------------------|----------------|
| Surname: Forename(s):           | Date of Birth: |
| Marital status: Previous Surnam | e:             |
| Current Address:                |                |
|                                 | Postcode:      |
| Home tel: Mo                    | obile:         |
| Previous Address                |                |
|                                 |                |
|                                 | Postcode:      |
| Email address:                  |                |
| Previous GP Name & Address      |                |
|                                 |                |



Reviewed and changed: March 2019

| First la | anguage:     |                                   | Do you require an interpreter? Yes / No   |  |
|----------|--------------|-----------------------------------|---|--|
| Count    | ry of Birth: |                                   | Date you first entered to live in UK:   |  |
| Ethni    | ic Origin    |                                   |   |  |
| health   | problems     | _                                 | npulsory, but may help with your healthcare, as some mmunities, and knowing your origins may help with ons. |  |
| Choos    | se ONE sect  | tion from A to E, and then tick C | ONE box to indicate your background.  |  |
| Α        | White        |                                   |   |  |
|          |              | British                           |   |  |
|          |              | Irish                             |   |  |
|          |              | Any other white background        | , please state:   |  |
| В        | Mixed        | •                                 |   |  |
|          |              | White and Black Caribbean         |   |  |
|          |              | White and Black African           |   |  |
|          |              | White and Asian                   |   |  |
|          |              | Any other mixed background        | d, please state:  |  |
| С        | Asian or A   | Asian British                     |   |  |
|          | 1010111      | Indian                            |   |  |
|          |              | Pakistani                         |   |  |
|          |              | Bangladeshi                       |   |  |
|          |              | Any other Asian background        | l, please state:  |  |
| D        | Black or B   | Black British                     |   |  |
|          |              | Caribbean                         |   |  |
|          |              | African                           |   |  |
|          |              | Any other black background        | , please state:   |  |
| E        | Chinese o    | or other ethnic group             |   |  |
| _        | 555.0        | Chinese                           |   |  |
|          |              | Any other, please state:          |   |  |
|          | <u> </u>     | 1                                 |   |  |



Reviewed and changed: March 2019

## Medication

| Please give details of any medication which you take (prescribed or otherwise):   |
|---|
| Name of drug:   |
| Dosage:   |
| Name of drug:   |
| Dosage:   |
| Name of drug:   |
| Dosage:   |
| <b>Note:</b> Proof will be needed before we can issue a repeat prescription i.e. copy of repeat slip from previous GP or labelled box |
| Do you have a Pacemaker? Yes / No If so, when?  |
| Allergies   |
| Are you allergic to any substances, including medication or foods? Yes / No   |
| If Yes, please give details:  |
|   |
| Carers  |
| Does someone look after you? Or do you need / have anyone who  Yes / No looks after you or your daily needs as a Carer?               |
| If Yes, would you like them to deal with your health affairs here?  Yes / No The receptionist can help with these arrangements        |
| Do you look after someone else? Yes / No If so, who e.g. Spouse/Parent?   |



Date of completion of this form: .....

Version 1.2 Date published: January 2019

Reviewed and changed: March 2019

## General

| Are there any other issues which cause you concern or would you like advice on any other health |
|---|
| problems? Please give details below:  |
|   |
|   |

Thank you for completing this questionnaire. Your doctor will assess the information provided and will invite you for an initial examination, discussion about your health, and general check within the next few days.

| OFFICE USE ONLY               |  |  |  |  |
|-------------------------------|--|--|--|--|
| Proof of Address 1            |  |  |  |  |
| Proof of Address 2            |  |  |  |  |
| Photo ID                      |  |  |  |  |
| Checked By:                   |  |  |  |  |
| New Patient Appointment Date: |  |  |  |  |