

Jubilee Field Surgery New Patient Registration Questionnaire

Please complete this confidential questionnaire **in full**. This will give us the information we need while we await your medical record from your previous practice and will ensure that your record is up-to-date and accurate.

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

If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.

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:			
				E-mail Address:			
				Next of Kin:			
				Next of Kin Contact Number:			
Date of Birth:		Previous / Mother's surname if different:		Town & Country of Birth:			
Marital Status:		Gender:	Male	Female	Are you happy to be contacted by the practice via (please tick):	Text message	<input type="radio"/>
Occupation:						Email	<input type="radio"/>
Names & Ages of Dependent Children:				Names of parents (if child):			
Housing (Select one)	House	Maisonette	Flat	Mobile Home	NHS Number (if Known)		
Previous Address				Previous Postcode:			
				Previous Doctor Telephone No.			
Previous Doctor Name & Address:				Previous data released?	Yes	No	
				If applicable, date you first came to live in Britain:			
If returning from Armed Forces:		Your Service or Personnel Number		Your Enlistment Date			
Your height:	Feet / inches	cm	Your weight:	Stones / lbs.	kg		

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)		
Do you require an interpreter?		Yes	No				
Smoking, Alcohol Consumption and Exercise:							
Are you currently a smoker?		Yes	No	Have you ever been a smoker?		Yes	No
If so, how many cigarettes / cigars / tobacco do you smoke in a week?			<i>If you are a smoker and want to stop, please ask for information about local smoking cessation services. Alternatively, please visit the Wiltshire Council Health Improvement Coaches webpage: https://www.wiltshire.gov.uk/public-health-improvement-coaches</i>				
Go Smoke free:- www.nhs.uk/smokefree							
How often do you exercise?		No. times per week		Type(s) of exercise:			
How much alcohol do you drink in a week (Units)?							
PLEASE COMPLETE THIS BOX based on your scores below - THANK YOU → <input type="text"/>							
<i>(One unit = 1 small glass of wine, a single measure of spirits, or 1/2 a pint of beer)</i>							
Question	Score			Please tick which applies			
How often do you have a drink containing alcohol?							
Never	0 points						
Monthly or less	1 point						
2-4 times per month	2 points						
2-3 times per week	3 points						
4+ times per week	4 points						
How many units of alcohol do you drink on a typical day when you are drinking?							
1-2 drinks	0 points						
3-4 drinks	1 point						
5-6 drinks	2 points						
7-9 drinks	3 points						
10+ drinks	4 points						
How often do you have 6 or more units if female, or 8 or more if male, on a single occasion in the last year?							
Never	0 points						
Less than monthly	1 point						
Monthly	2 points						
Weekly	3 points						
Daily or almost daily	4 points						

Your Medical Background:			
What illnesses have you had & When?			
What operations have you had and When?			
Do you have any medical problems at present?			
Please list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency)			
Are you able to administer your own medicines?	<table border="1"> <tr> <td>Yes</td> <td>No – please detail specific issues (e.g. swallowing, opening containers)</td> </tr> </table>	Yes	No – please detail specific issues (e.g. swallowing, opening containers)
Yes	No – please detail specific issues (e.g. swallowing, opening containers)		

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

Are there any serious diseases that affect your Parents, Brothers or Sisters (tick all that apply and state the family member affected)	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):						
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:						
Please state any allergies and sensitivities you have:						
Please state any phobias you have:						
If you are a Carer, please state the name / address / phone number of the person you care for:		<u>Person Cared For Contact Details:</u>				

<p>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.</p>	<p><u>Carer Contact Details:</u></p> <p><u>Signed:</u> _____ <u>Date:</u> _____</p>		
<p>Summary Care Records</p> <p>Your Summary Care Record is a short summary of your GP medical records. It tells other health and care staff who care for you about the medicines you take and your allergies. More information can be found on our practice website.</p>			
<p>Are you happy to have a Summary Care Record?</p>	Yes	No	More Time Required to decide:
<p>Do you have a "Living Will" (a statement explaining what medical treatment you would not want in the future)?</p>	Yes / No	<p><i>If "Yes", can you please bring a written copy of it to your New Patient Consultation</i></p>	
<p>Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)?</p>	Yes / No	<p>If "Yes", please state their name / address / phone number:</p>	
<p>Patient Participation Group</p> <p>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.</p> <p>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 sent to you.</p>			
<p>Yes, I am interested in becoming involved in the Practice Patient Participation Group (Please tick the "Yes" Box)</p>			Yes
<p>Patient Signature:</p>		<p>Signature on behalf of Patient:</p>	

Thank you for completing this form