Thorpe Bay Surgery

New Patient Registration Questionnaire

It can take several weeks and sometimes months to obtain your original notes, therefore any information you can provide will assist the doctors and nurses to assess your needs and risks and offer you appropriate healthcare. Please complete this form giving as much information as possible, once completed please return it to reception **along with a fresh urine sample in the bottle provided.** After this completed form has been reviewed you may be contacted and asked to book an appointment with a nurse or Health Care Assistant.

PLEASE PROVIDE US WITH A BP READING, YOU CAN USE OUR SELF SERVICE MACHINE FOR THIS – PLEASE ASK AT RECEPTION

Personal Details

Title MR/MRS/MISS/MASTER/OTHER (please circle)

Name…… Date of Birth……..

Address……

……

NHS number if know……

Please tick preferred contact number.

Home no:…….. Mobile No:…….. E-Mail……..

Height…… Weight…….. Occupation……

Ethnicity……

Place of Birth……..

First Language if not English……..

Next of Kin (Relationship)…… Next of Kin ……..

Contact Number (Next of Kin)……

Are you a registered carer? YES/NO

Name of person you care for……..

Do you have a carer? YES/NO

Name of carer…… Contact number of carer……..

Are you registered blind or partially sighted? YES/NO
Are you registered deaf? YES/NO
Are you registered disabled? YES/NO
Please specify disability. ……..

Medical History

Do you suffer from any of the following? Have you had a review in the last 12 months?

Heart Disease Y/N	Y/N
Stroke Y/N	Y/N
High Blood Pressure Y/N	Y/N
Asthma Y/N	Y/N
Diabetes:	
Type 1 Y/N	Y/N
Type 2 Y/N	Y/N
Chronic Obstructive Airways Disease Y/N	Y/N
Epilepsy Y/N	Y/N

Cancer Y/N
If yes please specify type……..
Any other serious illness Y/N
……..
Have you had any major operations or serious injuries? Y/N
If YES please give details including diagnosis, year and hospital attended.
……
……

Womens Health

No: of pregnancies / Livebirths……..
Miscarriage/Stillbirth……..
Rubella Status (if applicable)……..
Contraception
IUCD/IUS Date fitted
Cervical Smear Last smear date ……..Result…….

Family History (Parents, Brothers, Sisters and Grandparents ONLY)

Do you have a family history of any of the following?

1. Heart Attacks Y/N
2. Strokes Y/N
3. Breast Cancer Y/N
4. Ovarian Cancer Y/N
5. Bowel Cancer Y/N
6. Diabetes Y/N

If yes to any of the above please give details including RELATIONSHIP, ILLNESS and AGE AT DIAGNOSIS.

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Smoking Status

Do you smoke YES / NO / EX-SMOKER

If so how many smoked daily – circle relevant

Less than 10 10 – 20 More than 20

If You are an Ex-Smoker what year did you stop?

If you would like support and advice to stop smoking - Please contact the Surgery and make an appointment with the Smoking cessation clinic.

Quit Smoking Advice

If you want to stop smoking, several different treatments are available from shops, pharmacies and on prescription to help you beat your addiction and reduce withdrawal symptoms.

The best treatment for you will depend on your personal preference, your age, whether you're pregnant or breastfeeding and any medical conditions you have. Speak to your GP or an NHS stop smoking adviser for advice. Find your nearest NHS Stop Smoking Service by calling the Smokefree National Helpline to speak to a trained adviser on 0300 123 1044.

Diet and Exercise

How would you class your diet (healthy/average/low fat/low salt etc): ……

……

Do you take regular exercise? Yes/No (If yes, please detail type of exercise and frequency):……..

Allergies

Are you allergic to any medications – if yes please give details……

Are you allergic to anything else if yes please give details……

Repeat Medications
Please attach a copy of your repeat medication slip from your previous GP surgery, if you do not have one please write out a list and attach

Immunisation History
Please give details of vaccinations received

Vaccine	Date	Vaccine	Date

Alcohol intake

Questions	Please tick				
How often do you have a drink that contains alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week
How may standard alcoholic drinks do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-8	10+
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

Named GP
All practices are required to provide patients with a named GP who will have overall responsibility for their care.
Your named GP will have overall supervision for the care and support that our surgery provides to you. This does not prevent you from seeing any of the others GP's in the practice, nor does it mean that this is the GP you are registered with.

Upon registration you will be allocated a named GP and advised of who it is via SMS (if you have consented to receive SMS), email or telephone. If you have not been contacted with this information within 4 weeks of registration please contact the surgery