**New Patient Registration Questionnaire**

Welcome to Attenborough Surgery, where our aim is to provide the highest quality health care to meet the needs of our patients by working in partnership. To process your registration we need to know some details about your medical history -operations, illnesses and medication. From your responses you may be asked to attend an appointment with a Nurse or Doctor.

If you are registering a child aged under 16 yrs, where possible please provide proof of address and ID, supported by official documents such as a birth certificate, together with your own ID. For children 6yrs and under please also bring in the childs red book or full immunisation history.

**Date of Registration: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_**

|  |
| --- |
| **Personal Details (Please use Block Letters)** |
| **First name:-**  | **Surname:-**  |
| **Address:-**      **Post Code:**  | **Date of Birth** |   | **Sex** | M F | [ ] [ ]  |
| **Home Tel** |   |
| **Work Tel** |   |
| **Mobile Tel** |   |
| **If previously registered with a GP in the UK please provide your NHS Number**  | **NHS No**  |
| **Can we contact you by Email- (we may use this communication method in the future). Yes/No** **E mail:**  | **Can we communicate with you using text? Yes/No**  |
| **Occupation** |    | **Next of Kin Name & relationship** |   |
| **Next of Kin Contact No** |   |
| **Do you require help quitting smoking** | Yes / No | **How many times a week do you exercise for more than 30 minutes?**  |     |
| **Smoking Information**[ ]  Never smoked[ ]  Pipe smoker Per day\_ \_[ ]  Cigar smoker Per day\_ \_[ ]  Cigarette smoker Per day\_ \_[ ]  Ex SmokerYear gave up\_ \_ | **Alcohol consumption** |  |
| Units per week |   |
| *1 unit=* |  |
| *½ pint beer* |  |
| *1 glass wine* |  |
| *1 measure spirit* |  |
| **Do you have a special diet (please specify)** |   |
| **Which surgery would you normally prefer to attend? (please tick)**  | Main Surgery Bushey [ ] Branch-Carpenders Park [ ] Branch-Holywell [ ] Branch-Tudor [ ]  |
| **Please specify the name of your preferred doctor?** |
|  |  |
| **Family History** |
| **Relationship** | **Any Serious Illnesses** | **Relationship** | **Any Serious Illnesses** |
| Mother |   | Father |   |
| Brothers | 1. 2. 3.  | Sisters | 1. 2. 3.  |
| Husband |   | Wife |   |
| Children | 1. 2.  | 3. 4.  |

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| **Personal Medical History** |
| **Do you or have you ever suffered from any of the following illnesses?** |
| [ ]  | Heart Disease | [ ]  | Epilepsy |
| [ ]  | Stroke | [ ]  | Thyroid Disease |
| [ ]  | High Blood Pressure | [ ]  | Cancer |
| [ ]  | Current Mental Health Problems | [ ]  | Diabetes  |
| [ ]  | Emphysema / Bronchitis | [ ]  | Asthma |
| **Have you had any operations? (continue on a separate sheet if required)** |
| Date | Operations – details |
|   |   |
|   |   |
|   |   |
| **Do you have any allergies or had any reactions to any drugs or medication?** |
| To what? | What happens? |
|   |   |
|   |   |
|   |   |
| **Please list all medication that you currently take. (continue on a separate sheet if required) PLEASE BE ADVISED, YOU WILL BE EXPECTED TO HAVE A NEW PATIENT MEDICATION REVIEW BEFORE WE CAN ISSUE YOU ANY MEDICATION. PLEASE MAKE SURE BEFORE REGISTERING WITH US, THAT YOU HAVE REQUESTED ENOUGH MEDICATION WITH YOUR EXISTING GP FOR AT LEAST 4 WEEKS.**  |
|   |   |
|   |   |
|   |   |
| **Please list any immunizations you have had** |
| **Children aged 6 and under** |  |
| Immunisations (Please bring in Red book)  | Date |
| Age 2 mths-1stDTaP/IPV/Hib/PCV/Men B1/Rotavirus |   |
| Age 3 mths-2ndDTaP/IPV/Hib+Rotavirus  |   |
| Age 4 mths-3rdDTaP/IPV/HiB+2ndPCV+2ndMen B1  |   |
| Age 12 mths – Hib / Men C/3rd PCV/MMR/ 3rd MenB1 |   |
| Age 2-7yrs Influenza |   |
| Age 3 yrs +4months -Preschool booster DTaP/IPV/2nd MMR  |   |
| Girls Age 12 to 13 yrs HPV 2 doses  |   |
| Other (pls specify)  |   |
| **DIY Registration Medical** |
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| **Blood Pressure** (over 16 only) /  |
| **Height cm** |
| **Weight kg** |

 |
| **Women only** |
| **Births** | **Miscarriages** |
| Date | Complications | Date | How many months |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
| Last Cervical smear result | Date  | Result  |

The Department of Health now requires us to record patient ethnicity. The UK is an increasingly diverse society. Information on ethnicity is important because of the need to take into account culture, religion and language in providing appropriate individual care.

**What is your ethnic group ?**

*Choose ONE section from A to E, then circle the appropriate ethnic group-*

|  |  |
| --- | --- |
| **A : White** | Choose an item. |
| **B : Mixed** | Choose an item. |
| **C : Asian or** **Asian British** | Choose an item. |
| **D : Black or** **Black British** | Choose an item. |
| **E : Chinese or****Other ethnic group** | Choose an item. |
| **Not stated** |[ ]
|  |  |
| **What is your first language?** |   |

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| **IMPORTANT****IF YOU NEED INFORMATION ABOUT YOUR SUMMARY CARE RECORD AND WHAT IT MEANS TO YOU, THEN PLEASE ASK FOR AN INFORMATION PACK.** |

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| **You may be eligible for Latent TB testing** **1/ Were you were Born or have you spent over 6 months in high TB incidence country? (see list below)**YES [ ]  NO [ ] Please state country: …… ……**2/ Did you enter the UK within the last 5 years (including where entry was via other countries (e.g. with in EU/EEA)** YES [ ]  NO [ ] **3/ Do you have a history of TB either treated or untreated?**YES [ ]  NO [ ] **4/ Have you been screened for TB in the UK before?** YES [ ]  NO [ ] Central African Republic, Afghanistan, Angola, Bangladesh, Benin, Bhutan, Botswana, Burkina Faso, Burundi, Cote d'Ivoire, Cabo Verde, Cambodia, Comoros, Cameroon, Congo, Chad, Djibouti, Eritrea, Ethiopia, Equatorial Ghana, Greenland, Guinea, Gabon, Haiti, India, Indonesia, Korea, Kenya, Kiribati, Liberia, Madagascar, Malawi, Mali, Marshall Islands, Mauritania, Mauritius, Micronesiam, Mongolia, Mozambique, Myanmar, Namibia, Nepal, Niger, Nigeria, Pakistan, Papua New Guinea, Philippines, Republic of Moldova, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Gambia, Sierra Leone, Somalia, South Africa, Guinea, South Sudan, Guinea-Bissau, Swaziland, Timor-Leste, Togo, Tuvalu, Tanzania Uganda,  |
| **For office use only** |
| Form checked by:Date: | Proof of identity and address for every child, supported by official documentation such as a birth certificate. | Documents Seen?YES □NO □ | Proof of ID for Adult. | Documents Seen?YES □NO □ |

**Accessible Information Standard**

Attenborough Surgery wants to ensure that any patient registering with us who has particular information and/or communication needs relating to or caused by a disability, impairment or sensory loss has their needs met in relation to us providing their health care.

In order to complete your registration we would like to understand your preferred method of communication so that we can work with you, your carers, family members, support workers and other individuals involved in your care to maximise your involvement and inclusion in your health care.

An alert will be put on to your medical record so that all members of both our clinical and administrative team at Attenborough Surgery are aware of your needs with regards to your medical care.

|  |  |
| --- | --- |
| **Disability, Impairment of Sensory Loss** | **Best Method of Communication for Administration** |
| Deafness or Hearing Loss |   |
| Blind or some visual loss |   |
| Learning Disability |    |
| Other Disability |     |
| **Disability, Impairment of Sensory Loss** | **Best Method of Communication during Medical Appointments** |
| Deafness or Hearing Loss |   |
| Blind or some visual loss |   |
| Learning Disability |   |
| Other Disability |     |

Do you consent to us sharing your preferred method of Communication with other Clinical Services in relation to your healthcare? (please delete as appropriate)

 YES / NO



***DO YOU CARE FOR SOMEONE WHO IS ILL, FRAIL, DISABLED OR MENTALLY ILL?***

**Then you are a carer and we would like to support you.**

We hold a register of Patients who are Carers; if you would like to be added to this please complete this form and hand it in to reception who will record this information in your notes.

Being on the register ensures that you benefit from annual Flu Vaccinations, Health Checks and Flexible appointments.

Our Surgery Carers Champion is :-

**YOUR DETAILS**

|  |  |
| --- | --- |
| Name |    |
| Date Of Birth |   |
| Address |      |
| Post Code |   |
| Telephone Number |   |
| Any relevant information |         |

**Would you like to be referred to Carers in Hertfordshire?**

A countywide service providing carers with information and advice on caring, support services, training sessions and workshops, newsletters and the opportunity to influence service providers.

Then please complete and sign the enclosed referral form and return to the surgery along with your registration documents.

**CARER IDENTIFICATION AND PROFESSIONAL REFERRAL FORM**

|  |  |
| --- | --- |
| **Carers in Hertfordshire** is countywide providing carers with information and advice on caring, support services, training sessions and workshops, newsletters and the opportunity to influence service providers. *Carers in Hertfordshire* services are free of charge, please feel free to telephone our Carer Support Advisors on 01992 586969 for advice and support | Email Signature LOGO STACKED |

**Please complete the following sections in BLOCK CAPITALS**

|  |
| --- |
| Carer’s details will be added to Carers in Herts database. We will not share this information with anyone else without carer’s permission.Would carer like Carers in Herts to inform their GP of their caring role enabling them to access health checks, flu vaccines and appointments that meet their caring needs? YES [ ]  NO [ ] (please tick)  |
| **Title:**  | **Forename/s:**  | **Surname:**  | **DOB:**  |
| **Address:** No or name of house:  Road Name:  Town:  County: Post Code:  |  **Contact Telephone Number:**Home: Work: Mobile: Email:  |
| **Ethnicity:**  | **Primary Language Spoken:** | **Name of GP Surgery:**  |
| **Carers own health/conditions** |
| **Employment Status:**  (please tick)Working Full time [ ]  Working part time [ ]  Retired [ ]   Student [ ]   |
| **Relationship of the carer to the cared for:**  | **Name of cared for:**  |
| **DOB of cared for:** | **When did the caring role start?**Month Year  |
| **Health/conditions of cared for:** |
| **How would carer like to receive our newsletter ‘Carewaves’ please indicate by ticking preferred option:** by email [ ] or by post [ ]  |

GP’s authority for “Making a Difference for Carers” funding [ ]

Carer’s Signature: Date:

|  |  |  |
| --- | --- | --- |
| **Carers in Hertfordshire****The Red House****119 Fore Street****Hertford****Herts****SG14 1AX** | **To contact us:****Telephone:** 01992 586969**Fax:** 01992 586959**Email:** contact@carersinherts.org.uk**Website:** www.carersinherts.org.uk | Referring Professional’s Address or stamp here please. **Attenborough Surgery, Bushey Medical Centre, London Road, Bushey Herts WD23 2NN****Tel:01923** **231633** |

**Please return forms to the address above**