GREENWAY COMMUNITY PRACTICE

CHOOSING HEALTH

PATIENT REGISTRATION FORM

Please complete ALL questions on both sides of the form AND return it to Reception

PERSONAL DETAILS:

Surname: ..... **First Name(s):** .....

Title: Mr / Dr / Mrs / Miss / Ms **Date of Birth:** .....

Telephone: Home: ..... **Mobile:** .....

E-mail Address: ..... **Practice Surveys** – would you be happy for us to contact you from time to time to complete a survey on-line? **YES/NO**

Are any OTHER members of your household/family registered with this practice? .....

Ethnic Origin			**Please tick**
White	.9i0	British	
	.9i1	Irish	
	.9i2	Other White background	
Mixed	.9i3	White and Black Caribbean	
	.9i4	White and Black African	
	.9i5	White and Asian	
	.9i6	Other mixed background	
Asian or Asian British	.9i7	Indian	
	.9i8	Pakistani	
	.9i9	Bangladeshi	
	.9iA	Other Asian background	
Black or Black British	.9iB	Caribbean	
	.9iC	African	
	.9iD	Any other Black background	
Other Ethnic	.9iE	Chinese	
	.9iF	Any other ethnic group	
Other	.9iG	Not stated / patient does not wish to divulge	
Is your first language English? **Yes** ( ) **No** ( )		**Please specify**	

SMOKING (please ✓ appropriate box)

( ) "I have NEVER smoked"

( ) "I CURRENTLY smoke" ..... cigarettes / cigars / ..... oz pipe tobacco per day

( ) "I used to smoke, but GAVE UP in: ....." ..... cigarettes / cigars / ..... oz pipe tobacco per day

( ) "I would like to join your Support-to-Stop Smoking Service"

Alcohol (please ONLY answer if 16 or over)	**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? Pint of regular beer / lager / cider = 2 units; Glass of wine = 2 units; Alcopop/can of lager = 1.5 units; Bottle of wine = 9 units Single measure of spirits = 1 unit	1 -2	3 - 4	5 - 6	7 - 8	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	

PAST MEDICAL HISTORY: ***Please circle ALL that apply**

Have you EVER suffered from ANY of the following?*

Asthma High Blood Pressure Diabetes Depression/Anxiety Stroke/TIA

Glaucoma Cancer Heart Problems Chronic Kidney Disease

Have you had any OTHER major illnesses? Yes / No*

If **Yes**, please list: 1. ..... 2. .....

3. ..... 4. .....

Are you on any prescribed medication? Yes / No*

If **Yes**, please list: 1. ..... 2. .....

3. ..... 4. .....

Are you allergic to any drugs? Yes / No*

If **Yes**, please list: 1. ..... 2. .....

Are you registered disabled? Yes / No*

If **Yes**, please describe your needs: .....

Do you look after someone? Yes / No / Not sure*

If **Yes**, please specify: .....

FAMILY HISTORY: ***Please circle ALL that apply**

Have your parents, brothers or sisters ever suffered with any of the following illnesses?

Asthma High Blood Pressure Diabetes Depression/Anxiety Stroke Glaucoma

Cancer Heart Problems **before the age of 60** (e.g. heart attack or angina) High Cholesterol

Are you 25 or under? If you are sexually active and under 25 you should be tested for Chlamydia annually OR when you change your sexual partner. The test for Chlamydia is SIMPLE – just one quick and painless test that you do yourself. **You do NOT need to be examined!**

Pick up a self-testing kit at reception or in the toilet in the waiting room OR ask your doctor or nurse for your confidential free test.

FOR OFFICE USE ONLY:

Registration Form (GMS) ☐

Practice Questionnaire ☐

Photo ID ☐

Proof of Address ☐

Out of Area form given? ☐

Pt informed of named GP? ☐

New Patient Check offered: Yes / No / Refused

Received by: .....