ST MARY'S SURGERY

NEW PATIENT REGISTRATION QUESTIONNAIRE

To ensure our patient records are accurate, we would be grateful if you could supply the following information. Please answer as many questions as you can.

Contact Details:
Mr / Mrs / Miss / Ms / Doctor / Prof

First name(s):

Surname:

Date of Birth:

Previous Surname:

Home Address Including postcode:

Home Telephone number:
Mobile number:
Email:

Ethnic Group – Please tick which one you belong to

☐ British ☐ Chinese ☐ Asian or Asian British ☐ Indian or British Indian
☐ Black or Black British ☐ European ☐ Other Ethnic group – please specify

Medical History – Please list any serious illnesses/operations (and for women any pregnancy related problems) and if possible the year they took place

Have you ever suffered from?

	YES	NO		YES	NO
Epilepsy			Blindness/Glaucoma		
High Blood Pressure			Diabetes		
Heart Disease			Mental Health problems		
Stroke			Asthma		
Cancer			COPD		
Atrial Fibrillation			Dementia		

Medication
Are you taking any regular medication YES / NO

Are you taking any medication prescribed directly from a hospital? YES / NO

This practice issues electronic prescriptions, therefore no paper ones are issued. Please nominate a pharmacy you would like your prescriptions to be sent to.

The pharmacy I would like to nominate is:

Are you allergic to anything including medicines? (Please state what in the box)

Women
Have you ever had a cervical smear? (Please enter details in the box)

Smoking

Do you smoke? YES / NO If No, have you ever smoked? YES / NO

If you currently smoke, how many cigarettes / cigars / ounces of tobacco do you smoke per week?

Alcohol

How many units of alcohol do you consume weekly?

(one unit is equivalent to ½ pint beer/lager, a small glass of wine or one pub measure of spirits)

Family History (Please tick all that apply)

	Family Member	Age at Diagnosis
Heart Disease		
High Cholesterol		
Stroke / TIA		
Diabetes		

Additional Information

Are you a carer? YES / NO If yes, who for?

Do you have a carer? YES / NO If yes, who?

Are you registered Disabled? (if yes, please give details) YES / NO

Do you have any communication needs? (e.g. large font letters / interpreter) YES / NO

Next of Kin

Please give title, name, address and telephone number of your next of kin

Title: Name: Address:	Relationship to you: Telephone number:

Are you happy to receive communication from the practice via text message and/or email? YES / NO

Please refer to our practice leaflet for further information

Signed: **Date:**

For Official use only:

Checked by ____________________________________ Registered on EMIS ____________________________________

EMIS No ______________________________________ Date ____

(Please make sure the patient does not have an EMIS number already)