



Patient's details

Please complete in **BLOCK CAPITALS** and tick as appropriate

<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms				Surname			
Date of birth				First names			
NHS No.				Previous surname/s			
<input type="checkbox"/> Male <input type="checkbox"/> Female				Town and country of birth			
Home address							
Postcode				Telephone number			

Please help us trace your previous medical records by providing the following information

Your previous address in UK				Name of previous doctor while at that address			
				Address of previous doctor			

If you are from abroad

Your first UK address where registered with a GP

If previously resident in UK, date of leaving				Date you first came to live in UK			

If you are returning from the Armed Forces

Address before enlisting

Service or Personnel number				Enlistment date			

If you are registering a child under 5

I wish the child above to be registered with the doctor named overleaf for Child Health Surveillance

If you need your doctor to dispense medicines and appliances*

**Not all doctors are authorised to dispense medicines*

I live more than 1 mile in a straight line from the nearest chemist

I would have serious difficulty in getting them from a chemist

Signature of Patient Signature on behalf of patient Date

NHS Organ Donor registration

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death. Please tick as appropriate

- Kidneys
 Heart
 Liver
 Corneas
 Lungs
 Pancreas
 Any part of my body

Signature confirming consent to organ donation

Date

For more information, please ask for the leaflet on joining the NHS Organ Donor Register

NHS Blood Donor registration

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.

Tick here if you have given blood in the last 3 years

Signature confirming consent to inclusion on the NHS Blood Donor Register

Date

For more information, please ask for the leaflet on joining the NHS Blood Donor Register

My preferred address for donation is: (only if different from above, e.g. your place of work)

Postcode:

To be completed by the doctor

Doctors Name

HA Code

- I have accepted this patient for general medical services
 For the provision of contraceptive services
 I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice

Doctors Name, if different from above

HA Code

- I am on the HA CHSlist and will provide Child Health Surveillance to this patient **or**
 I have accepted this patient on behalf of the doctor named below, who is a member of this practice and is on the HA CHS list and will provide Child Health Surveillance to this patient.

Doctors Name, if different from above

HA Code

I will dispense medicines/appliances to this patient subject to Health Authority's Approval

I am claiming rural practice payment for this patient.
 Distance in miles between my patient's home address and my main surgery is

I declare to the best of my belief this information is correct and I claim the appropriate payment as set out in the Statement of Fees and Allowances. An audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission.

Authorised Signature

Name

Date

Practice Stamp

NEW PATIENT REGISTRATION

PERSONAL DETAILS

Surname
First Names (s)
Full Address
.....
Post Code
Tel. No. Home
Tel. No. Work
Tel. No. Mobile
(Please tick if you **do not** wish to be contacted by text)
Marital Status
Date of Birth
What is your first language?
Sex
Occupation

GENERAL HISTORY

Have you had any serious illnesses or operations, X-rays or similar tests and when?
.....
.....
.....
Allergies
What medicines are you currently taking?
.....
.....
.....

GENERAL HEALTH QUESTIONS

Do you drink alcohol? Yes No
How often do you have a drink containing alcohol
 Never, Monthly or less, 2-4 times a month,
 2-4 times a week, 4 times or more
How many standard drinks containing alcohol do you have on a typical day?
 1 or 2, 3 or 4, 5 or 6, 7 or 8, 10 or more
How often do you have six or more drinks on one occasion?
 Never, Less than monthly, Monthly, Weekly,
 Daily or almost daily
Do you smoke? Yes .../day No Previous smoker ... yrs.

FAMILY HISTORY

Which of your blood relations have suffered from the following before the age of 60?

Heart attack
Cancer
Diabetes
High Blood Pressure
Asthma
Stroke
Other serious illness
.....

FOR FEMALE PATIENTS ONLY

Have you had any children? Give ages
Have you had a hysterectomy? Date
What method of contraception are you using at present?
.....
When was your last smear test?

PATIENT ETHNIC ORIGIN QUESTIONNAIRE

This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act.

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

Choose ONE section from A to E, and then tick ONE box to indicate your background.

Name.....

Date of Birth.....

A White

<input type="checkbox"/>	British
<input type="checkbox"/>	Irish
<input type="checkbox"/>	Any other white background please write in below

B Mixed

<input type="checkbox"/>	White and Black Caribbean
<input type="checkbox"/>	White and Black African
<input type="checkbox"/>	White and Asian
<input type="checkbox"/>	Any other mixed background please write below

C Asian or Asian British

<input type="checkbox"/>	Indian
<input type="checkbox"/>	Pakistani
<input type="checkbox"/>	Bangladeshi
<input type="checkbox"/>	Any other Asian background please write below

D Black or Black British

<input type="checkbox"/>	Caribbean
<input type="checkbox"/>	African
<input type="checkbox"/>	Any other black background please write below

E Chinese or other ethnic group

<input type="checkbox"/>	Chinese
<input type="checkbox"/>	Any other please write below

<input type="checkbox"/>	Declined
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First language

FOR OFFICE USE ONLY Date

Urine () Glucose ()
 Waist () BP ()
 Weight () Height ()