PATIENTS WISHING TO REGISTER WITH THE ARLINGTON ROAD MEDICAL PRACTICE

Surname		**Forename**		**Date of Birth**	/ /
Address				**Postcode**	
Home Telephone No.		**Mobile Telephone No**			
Work Telephone No.		**Occupation**			
Email Address					

Consent	Do you give your consent for your email address to be used for the surgery to email you with information about the surgery? Yes ☐ Do you give your consent for the surgery to email you surgery newsletters? Yes ☐ If at any time you wish to opt out of the above consent please contact the Practice Manager.

Marital Status	Married ☐	Single ☐	Widowed ☐	Separated ☐	Divorced ☐

Ethnic Origin – please tick as appropriate (based on new national population Census categories)				
White:	Mixed:	Asian:	Black:	Chinese ☐
British ☐	White & Black Caribbean ☐	Indian ☐	Caribbean ☐	
Irish ☐	White & Black African ☐	Pakistani ☐	African ☐	
Scottish ☐	White & Asian ☐	Bangladeshi ☐		
Welsh ☐				
European ☐				
Other, please state		I do not wish an ethnic background to be stated ☐		

Communication Needs – Language	
What is your first language? Please state	
If your first language is not English, do you need an interpreter for any consultations? Please tick	Yes ☐ No ☐
Do you require any communications sent by the Practice to be in your first language? Please tick	Yes ☐ No ☐

Communication Needs – Hearing Impairment/Vision Impairment/Disability
If communicating with the Practice is difficult, due to a hearing or vision impairment or some form of disability, please tell us about it by completing the Communication Needs form that is included in your Registration Pack. Thank you.

Medical History - Have you had any serious illnesses in the past? For example, illnesses requiring hospitalisation or long term treatment? Please give details, with dates, if possible.	
Date	Illness

Surgical History - Have you had any operations? Please give details, with dates, if possible.	
Date	Surgery

Family History - Is there a history of any of the following illnesses in your near family? (Parents/Brothers/Sisters). If so, please give details.			
High Blood Pressure	Yes ☐ No ☐	Details	
Strokes	Yes ☐ No ☐	Details	
Heart Attacks/Angina	Yes ☐ No ☐	Details	
Diabetes	Yes ☐ No ☐	Details	
Allergy (eg Asthma/Eczema	Yes ☐ No ☐	Details	
Others	Yes ☐ No ☐	Details	

Lifestyle - If there are any factors in your lifestyle, housing, working environment or at home that you think might have a bearing on your health, please let us know:

Vaccination History - Have you ever had a Tetanus course?	Yes ☐ No ☐
If yes, please give the date of your last Tetanus Booster	

Medication – Are you taking any regular medication?			Yes ☐ No ☐
If yes, please give the details below…			
Name of Drug	Dose	Frequency/Day	Reason for taking it

Allergies – Are you allergic to any medications, tablets or injections?	Yes ☐ No ☐
If yes, please give the details below…	
Name of Drug	Type of reaction that occurred

Smoking Status – Do you smoke?	Yes ☐ No ☐
If yes, please give the details below…	
How many cigarettes per day?	
How much tobacco per day?	

Alcohol Status – Do you drink alcohol?	Yes ☐ No ☐
If yes, approximately how much alcohol do you consume on average each week?	
Number of single spirits?	
Number of glasses of wine?	
Number of pints of beer/lager?	

Females only – Obstetric & Gynaecological History			
Do you have children? If yes, please give details.			Yes ☐ No ☐
Date of Delivery	Normal Delivery / Forceps / Caesarean Section / Problems etc.		
Have you had any Miscarriages or Terminations of Pregnancy? If yes, please give details.			Yes ☐ No ☐
Date	Miscarriage / Termination		
Have you had a Hysterectomy?	Yes ☐ No ☐	If yes, date of operation	
Are you on any Contraception? If yes, please give details.			Yes ☐ No ☐
Name of Contraception			
Have you ever had a Cervical Smear Test?	Yes ☐ No ☐	If yes, date of last smear	
What was the result of your last Cervical Smear Test?	Normal ☐ Abnormal ☐		

THIS IS VERY IMPORTANT. IF YOU DO NOT KNOW THE EXACT DATE OF YOUR LAST SMEAR TEST PLEASE CONTACT YOUR PREVIOUS DOCTOR OR THE CLINIC WHERE THE TEST WAS DONE AND FIND OUT THE DATE AND RESULT – BEFORE YOU COME TO REGISTER WITH US.

Are you a Military Veteran? (Ex-Armed Forces) If yes, please give details.			Yes ☐ No ☐
Which Force did you serve in?	Air Force ☐ Army ☐ Navy ☐ Marines ☐		
Service Number		**Regiment/Corp**	
Do you have your discharge summary book (Regular Army Red Book) or a copy of your medical records?			Yes ☐ No ☐

Are you a Member of a Military Family? If yes, please give details.			Spouse ☐ Child ☐
Service Personnel Surname		**Service Personnel Forename**	
Service Personnel DOB	D D M M Y Y Y Y		
Which Force do they serve in?	Air Force ☐ Army ☐ Navy ☐ Marines ☐		
Service Number		**Regiment/Corp**	

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