Denton Park Medical Group
New Patient Registration Questionnaire
Tel: 0191 2295800

ADMIN ONLY

Admin:

Appt date:

Appt time:

With:

DNA Explained: ☐ Brochure given: ☐

ID Check: ☐ GMS1 Signed: ☐

Please hand in 2 forms of ID with this form before your appointment, one of which must be photographic i.e. passport or driving licence, the other, proof of address such as a utility bill.
If your child is under 6 years of age please bring their yellow/red hand held record to the registration appointment.

Title: Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐

Family name:

First names:

Male/Female (please circle)

Date of Birth:

NHS number:

Address:

Telephone number:
Mobile number:
Work number:
E-mail:

Previous Address:

Previous GP:
Previous GP Address:

Ethnicity:

What is your first language?

Do you speak English? Yes/No

Do you need an interpreter? Yes/No

Are you a refugee or asylum seeker? Yes/No

Country of origin:

Date arrived in UK:

Refugee ☐ Asylum Seeker ☐ (please tick)

Next of Kin:
Address:

Contact number:

Do you look after someone? Yes/No
Does someone look after you? Yes/No
Recent armed forces? Yes/No
Occupation:
School attended:

Disability: A disabled person is defined in the Disability Discrimination Act as someone with a physical or mental impairment that has a substantial and long-term impact on their ability to carry out day-today activities.

Having read this do you consider yourself to be covered by the definition? Yes/No (Please circle)

If yes, please state your disability:

Patient Forum

Would you like to share and represent the views of patients with fellow patients and the Practice?
Would you like to: •Attend monthly patient forum meetings? •Discuss issues and put forward views of patients?

Tick this box to join our Patient Forum ☐

Do you smoke? Yes/No

Are you an ex-smoker? Yes/No

Which of the following do you smoke:

Cigarettes ☐ Cigar ☐ Pipe ☐ Tobacco ☐

How many per day? _ _ _ _ _

Would you like to stop smoking? Yes/No

Women only:

How many children do you have?

When was your last Cervical Smear test?

Which type of contraception do you use?

_ _

Alcohol Screening: if you are **16** or **over** you must answer the following questions:

Questions	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 standard drinks containing alcohol do you have on a typical day when you are drinking?	**1-2**	**3-4**	**5-6**	**7-9**	**10+**	
How often do you have 6 or more standard drinks on one occasion?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**	

Approximately how many units of alcohol do you drink per week? _______

Does anyone in your family suffer from the following:

Heart Disease	**Yes/No**	**Family Member:**	**Age:**
Stroke	**Yes/No**	**Family Member:**	**Age:**
Diabetes	**Yes/No**	**Family Member:**	**Age:**
Asthma	**Yes/No**	**Family Member:**	**Age:**
Breast Cancer	**Yes/No**	**Family Member:**	**Age:**
Hypertension	**Yes/No**	**Family Member:**	**Age:**

Please list any current health problems:

Please list any significant past health problems:

Please list any current medication:

Please bring ALL medication or a copy of your prescription to your registration appointment

For GP or Nurse to complete:

Date: _ _ / _ _ / _ _ _ _ Seen By: _ _ _ _ _ _ _ _ _ Allergies: _

BP: _ _ _ / _ _ _ Weight: _ _ _ _ _ _ Height: _ _ _ _ _ _

Audit C Score: _ _ / 12 Full Audit Score: _ _ / 40 Brief Intervention: Yes/NO

Referred for specialist advice? Yes/No Name of Carer: _

Notes

Follow up:

Entered by: