Welcome to

Dr. Mahmood & Partners

Ravensthorpe Health Centre

New Patient Registration Form
For Children Age 5yrs to Adults

With reference to your enquiry with regard to registering as a 'New Patient' in our practice, in order for us to consider your application and begin registration process, we require you to complete all of the following items in accordance with our instructions as follows.

Documents obtained from our reception

These are your registration documentation which should be completed in full and return to the surgery with proof of identification. **THIS IS IMPORTANT** as we cannot book your appointment for 'patient screening' without the completed **DOCUMENTATION AND IDENTIFICATION.**

Your identification Could be any of the following: - **PASSPORT, DRIVING LICENCE IDENTITY CARD OR NHS NUMBER.**

Once your registration form has been accepted by the surgery, this will be passed onto the Gp who will check through your registration and sign to say he accepts your registration. Once signed we will contact you to make an appointment with the health Care Assistant, for your 'New Patient Screening Appointment'.

During your appointment, we will assess your immediate health care needs and check any ongoing medical conditions identified.

IT IS ESSENTIAL THAT YOU KEEP THIS APPOINTMENT, FAILURE TO DO SO WITHOUT PRIOR NOTIFICATION TO US WILL RESULT IN YOUR APPLICATION BEING IMMEDIATELY REJECTED AND YOU WILL NOT BE REGISTERED AT OUR PRACTICE.
OUR TELEPHONE NUMBER IS:- 01924 351510

There are another two practices in this health centre and you may also consider applying to join their list. If you do not wish to follow our registration processes you can apply to the local Health Authority who will allocate you to another practice.

Appt Day :- ________________

Appt time :-________________

Mohammed Zahoor

Practice Manager

UPDATED: 18/03/2015

DR. MAHMOOD & PARTNERS
RAVENSTHORPE HEALTH CENTRE
NEW PATIENT QUESTIONNAIRE

ADMINISTRATION **PATIENT DETAILS**

PLEASE COMPLETE IN BLOCK LETTERS
Please circle or tick as appropriate

Mr……….Mrs………Miss…….…Ms………..
SURNAME……….…………………...………………….

FIRST NAME(S)…………………………………………….
D.O.B…............………………………..

ADDRESS…………………………………………………
POSTCODE…………..………………..

HOME TEL NUMBER…………………………………………………………

MOBILE TEL NUMBER …..

EMAIL:……………………………………………………………………………..

Place of birth ……………………………………………………….

Marital status Married [] single [] divorced [] widow [] widower []

Occupation.……………………………………………(Please Specify)

Have you been registered with this practice previously? YES / NO
Have you been registered with any other practice in England? YES / NO

If you have <u>not</u> been registered in England – what date did you ENTER THE COUNTRY? ____________________________

What is your reason for wishing to register with this practice?...………………………………………
………………………………………………………………………………….

MAIN LANGUAGE SPOKEN……………………………………………………….

ENGLISH SPEAKER:- YES / NO

RELIGION…………………………………………………………………………

UPDATED: 18/03/2015

NHS Organisations are required to collect details about a patient's ethnic origin. This information is for monitoring purposes only.

I would describe my ethnic origin as:-

<u>White</u>

British………………………………………
Irish……………………………………..
Other white background……………………

<u>Mixed</u>

White & Asian…………………..
White & Black African…………
White &Black Caribbean……….
Other Mixed background……….

<u>Asian or Asian British</u>

Indian…………………………………..
Bangladeshi……………………………
Pakistani……………………………….
Other Asian ……………………………

<u>Black or Black British</u>

African………………
Caribbean……………
Other black background……

<u>Other Ethnic Group</u>

Chinese…………
Other ethnic group……………………

I do not wish to disclose my ethnic origin……………………………………….

<u>LIFESTYLE INFORMATION</u>

HEIGHT (approx)……………………………… WEIGHT (approx)………………………………………

WAIST CIRCUMFERANCE (approx) …………………………………………..

DO YOU SMOKE? YES…….. NO……… If YES how Many?..

IF YOU ARE OVER THE AGE OF 40 AND A CURRENT OR EX-SMOKER, YOU MAY HAVE A LUNG HEALTH ASSESSEMENT (SPIROMETRY) AT THE PRACTICE.

WOULD YOU LIKE TO HAVE A LUNG HEALTH ASSESSMENT(SPIROMETRY):YES…….NO…….

<u>PASSIVE SMOKING</u> – DOES ANYONE IN YOUR HOUSEHOLD SMOKE? YES NO

DO YOU DRINK ALCOHOL? YES……………... NO…………….

If YES how many units a week?..
(AUDIT C NEEDS COMPLETING)

DO YOU USE ILLEGAL DRUGS? YES…………….. NO……………………………

IF SO WHICH ONES?...

DO YOU TAKE EXERCISE? LIGHT…………. MODERATE………….. HEAVY……………

IS YOUR DIET POOR………………… AVERAGE……………….. GOOD……………….

DO YOU HAVE ANY KNOWN ALLERGIES?
YES……………………… NO…………………..

If YES please give details…………………………………………………………………………………..

DO YOU HAVE A CARER? YES NO

ARE YOU A CARER YES NO

IF YES PLEASE ASK THE RECEPTIONIST FOR A CARER'S INFORMATION FORM (SUPPORTING CARER'S)

<u>ARE YOU TAKING ANY MEDICATION AT PRESENT?</u>

YES………………. NO…………………..

If YES PLEASE LIST

NAME STRENGTH DOSE

………

………

………

………

………

CONTINUE ON A SEPARATE SHEET IF NECESSARY.

IS THERE ANY FAMILY HISTORY OF

Asthma……….... Diabetes…..……… Cancer…………. Heart Disease……….... Stroke…………………….

Other…………………………………………………………………………………………………….................

DO YOU HAVE ANY KNOWN ALLERGIES? YES…………………….. NO…………………..

If YES please give details………………………………………………………………………………

DO YOU SUFFER FROM ANY OF THE FOLLOWING? IF YES PLEASE GIVE THE APPROXIMATE DATE OF DIAGNOSIS.

ARTHRITIS………..HEART ATTACK…………STROKE…………….CANCER………………

ANGINA…………….DIABETES…………………..EPILEPSY… ………. ASTHMA…………….

HIGH BLOOD PRESSURE………………… DEPRESSION ………………………………….

HAVE YOU HAD ANY ILLNESSES, ACCIDENTS OR OPERATIONS IN THE PAST?
YES…………NO…………..IF YES PLEASE GIVE DETAILS AND APPROXIMATE DATE BELOW

…………………………………………………………………………………………

…………………………………………………………………………………………

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UPDATED: 18/03/2015

ARE YOU UNDER THE CARE OF A SPECIALIST AT THE MOMENT? YES……….NO……….

IF YES PLEASE GIVE THE NAME OF THE SPECIALIST, HOSPITAL AND

DIAGNOSIS……………………………………………………………………………………………………..

WOMEN ONLY

HAVE YOU EVER BEEN PREGNANT? YES………… NO…………..

HAVE YOU EVER HAD PROBLEMS CONNECTED WITH PREGNANCY?

YES………... NO………… IF YES PLEASE GIVE DETAILS AND DATES

…….

…….

…….

ARE YOU USING ORAL CONTRACEPTION? YES………………... NO………………………..

WHEN WAS YOUR LAST SMEAR TEST? .... RESULT………………………………