chapeltown family surgery
New Patient Registration Form

Please complete this confidential questionnaire (one for each member of the family to be registered with the Practice).

Please complete in BLOCK CAPITALS and tick the boxes as appropriate.

If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.

Full Name:					Telephone Number:	
Mr / Mrs / Miss / Ms / Other.....					Work Number	
Address and Postcode					Mobile Number:	
					E-mail Address:	
					Next of Kin:	
					Next of Kin Contact Number:	
Date of Birth:		Previous / Mother's surname if different:			Town & Country of Birth	
Marital Status:		Gender:	Male:	Female:	Other residents of your home:	
Occupation:						
NHS Number (If Known)						
Date entered uk						
Previous Address					Previous Postcode:	
					Previous Doctor Telephone No.	
Previous Doctor Name & Address:					Previous data released?	Yes / No
					If applicable, date you first came to live in Britain:	
Your height:	Feet / inches	cm	Your weight:		Stones / lbs.	kg
Your Religion:	C of E	Catholic	Other Christian (state)		Buddhist / Hindu / Muslim	

	Sikh	Jewish	Jehovah's Witness	No religion	Other religion (state)

Your Ethnic Origin: (select one)	White (UK) 9i0	White (Irish) 9i1%	White (Other) 9i2%
Caribbean 9i3	African 9i4	Asian 9i5	Other Mixed Background 9i6%
Indian / Brit Indian 9i7	Pakistani / Brit Pakistani 9i8	Bangladeshi / Brit Bangladeshi 9i9	Other Asian Background 9iA%
Other Black Background	Chinese 9iE	Other 9iF%	Ethnic Category not stated 9iG

Your main or 1st language Spoken / Understood: (select one)	English	Hindi	Gujurati	Urdu	Bengali /Sytheti	Punjabi

Polish	Ukrainian	French	German	Spanish	Other: (Please Specify)

Smoking, Alcohol Consumption and Exercise:

Are you currently a smoker?	Yes	No	Have you ever been a smoker?	Yes	No

If so, how many cigarettes / cigars / tobacco do you smoke in a week?		How much alcohol do you drink in a week (Units)? *(One unit = 1 small glass of wine, a single measure of spirits, or 1/2 a pint of beer)*	
If you are a smoker and want to stop, please ask for information about local smoking cessation services.			

How often do you exercise?	No. times per week	Type(s) of exercise:	

Your Medical Background:

What illnesses have you had & When?	
What operations have you had and When?	
Do you have any medical problems at present?	
Please list any tablets, medicines or other treatments you are currently taking: (incl. dose +	

frequency) Please have pharmacy translate any prescribed abroad	

Are there any serious diseases that affect your Parents, Brothers or Sisters (tick all that apply)	Diabetes	Heart Attack	Heart attack under age of 60	Bowel Cancer		
	Breast Cancer		High Blood Pressure	Asthma	Stroke	
	Thyroid Disorder		Any other important Family Illness?			

What immunisations have you had? (please tick all that apply)	Diphtheria	Measles	German Measles	Tetanus	Polio	MMR
	Whooping Cough		Pre-school booster	Triple vaccine (Diphtheria, Tetanus & Pertussis) – 3 doses		

Specific Needs: Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:	
Please state any Sensory Impairment you have (i.e. Speech, Hearing, Sight):	
Are you an 'Assistance Dog' User?	
Please state any Physical disabilities you have:	
Please state any Mental disabilities you have:	
Please state any requirements you have to be able to access the Practice premises	
Please state any Religious or Cultural needs:	
Do you require the help of a Translator / Interpreter?	
Please state any specific nutritional requirements you have:	
Please state any allergies and sensitivities you have:	
If you are a Carer, please state the name / address / phone number of the person you care for:	Person Cared For Contact Details:

If you have a Carer, please state their name / address / phone number and sign here if you wish us to disclose information about your health to your Carer.	Carer Contact Details: Signed: Date:	
Do you have a "Living Will" (a statement explaining what medical treatment you would not want in the future)?	Yes / No	*If "Yes", can you please bring a written copy of it to your New Patient Consultation*
Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)?	Yes / No	If "Yes", please state their name / address / phone number:

Women only:

When was your last smear done?	Date	Was this at your GP's Surgery?	Yes	NO
What was the result of the smear?				
Date of last mammogram (if applicable):	Date	Method of contraception (if used):		
Do you wish to see a doctor in this practice for contraceptive services (including the pill, coil or cap)?			Yes	NO

Patient Participation Group

The Practice is committed to improving the services we provide to our patients.
To do this, it is vital that we hear from people about their experiences, views, and ideas for making services better.
By expressing your interest, you will be helping us to plan ways of involving patients that suit you.
It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice.
If you are interested in getting involved, please tick the box below and we will arrange for the Practice Patient Participation Group Application Form to be given to you at your initial consultation.

Yes, I am interested in becoming involved in the Practice Patient Participation Group (Please tick the "Yes" Box)	Yes

Patient Signature:		Signature on behalf of Patient:	

Thank you for completing this form