ABBEY MEDICAL CENTRE

63 Central Avenue
Beeston, Nottm NG9 5EA
Tel: 0115 9255323

Patient Registration

Confidential Questionnaire - Thank you for completing. All fields are essential for registration

PERSONAL & CONTACT DETAILS:		
Surname:	First Names:	
Previous Surname:	Place of Birth:	
Ms / Miss / Mrs / Mr *(please circle)* Other:	Marital Status:	
	Occupation:	
Date of Birth:	**Contact Phone Numbers**	
Address:	Home:	
	Work:	
	Mobile:	
	Who can we contact in an **emergency**?	Name:
Postcode:		Phone No:

MEDICATION: *if you are taking any regular medication please list below or attach your 'repeats' list*

PERSONAL HISTORY:

Please note any longer term illnesses you are currently suffering from: (eg. diabetes, asthma, heart disease, epilepsy, thyroid disease, kidney disease, depression)

Female patients only:

When was your last smear test?	What was the result?
Please provide details of any current contraception:	

VACCINATION HISTORY For all children & for children from abroad

For all Children: *(VERY IMPORTANT)*	Dates		Dates
1st Immunisations		1st MMR	
2nd Immunisations		2nd MMR	
3rd Immunisations		Pre-school Booster	
1st Hep B		BCG	
2nd Hep B		Meningitis C	
3rd Hep B		Hib	
4th Hep B		Others	

FAMILY HISTORY: *Please tick (and add details) if you have any family history of these conditions*

√	Type of Disease	Family Member(s)	<65 y.o.	>65 y.o.
	Cancer *(specify type)*			
	Diabetes			
	Heart Attack/Angina			
	High Blood Pressure			
	Stroke			
	Asthma			
	TB			
	Other *(please specify)*			

Please turn over

ALLERGIES:	Do you have any allergies?	Yes: ☐	No: ☐
If 'Yes' please list:			

WEIGHT: *st. & pd. or kg* **EXERCISE:** *What exercise do you do?* *Do you follow a special diet?*	**HEIGHT:** *ft. & in. or cm*

SMOKING:	Do you smoke?	Yes: ☐ No: ☐
If 'Yes' please advise how much:	Amount	Type of tobacco
		Cigarettes per day
		Oz. per week (roll your own or pipe)
		Cigars per day

If you would like help to stop smoking we offer a specialist service – details available at reception.

Are you an ex-smoker? Yes: ☐ No: ☐ When did you stop? *(year)*:

ALCOHOL: 1 UNIT = ½ pint of beer/1 small glass of wine/1 single shot of spirits

QUESTIONS:	**SCORING**					**YOUR SCORE**
	0	**1**	**2**	**3**	**4**	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4+ times a week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
Women-how often have you had 6 or more units/ Men-how often have you had or 8 or more units: On a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily/ almost daily	

Are you a Carer? *(there may be help available if you are)*	Yes: ☐	No: ☐
If 'Yes' please give details of the person you are caring for:		
Full name:		
Your relationship to them: *(eg. partner, parent, son, neighbour, etc)*		
Are you cared for? *(there may be more help available if you are)*	Yes: ☐	No: ☐
If 'Yes' please give details of the person caring for you:		
Full name:		
Address:		
Contact Phone Details:		
Your relationship to them: *(eg. partner, parent, son, neighbour, etc)*		

ETHNICITY: *(we are asked by the NHS to record your ethnic origin according to the following categories)*

Please tick the most appropriate box		√			√
British or mixed British			Pakistani or British Pakistani		
Irish			Bangladeshi / British Bangladeshi		
Other white background			Other Asian background		
White & black Caribbean			Caribbean		
White & black African			African		
White & Asian			Other black background		
Other mixed background			Chinese		
Indian or British Indian			Other ethnic category		

FIRST LANGUAGE: (*essential*)

Signed: Date:

As soon as you have completed this and the GMS1 form and returned them to us, you are registered
Please book a new patient health check with the practice nurse

Welcome to Abbey Medical Centre