The Medical Centre
140 Holloway Road
London N7 8DD

Today's Date:

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.

Please bring a Passport/Driving Licence to confirm your date of birth and address.

<table>
<tr><td colspan="3">Full Name:</td><td colspan="3">Telephone Number:</td></tr>
<tr><td colspan="3">Mr / Mrs / Miss / Ms / Other……..</td><td colspan="3">Work Number</td></tr>
<tr><td colspan="3" rowspan="8">Address and Postcode</td><td colspan="3">Mobile Number:</td></tr>
<tr><td colspan="3">E-mail Address:</td></tr>
<tr><td colspan="3">Preferred way to contact you re non-confidential info:</td></tr>
<tr><td colspan="3">Next of Kin:
Mr / Mrs / Miss / Ms / Other…
Full Name:</td></tr>
<tr><td colspan="3">Can they discuss your medical records? Yes / No</td></tr>
<tr><td colspan="3">How they are related:</td></tr>
<tr><td colspan="3">Next of Kin Contact Number:</td></tr>
<tr><td colspan="2">Date of Birth:</td><td colspan="2">Previous / Mother's surname if different:</td><td colspan="2">Town & Country of Birth</td></tr>
<tr><td>Marital Status:</td><td></td><td>Gender:</td><td>Male:</td><td>Female:</td><td rowspan="3">Other residents of your home:</td></tr>
<tr><td colspan="4">Occupation:</td></tr>
<tr><td colspan="4">Names & Ages of Children</td></tr>
<tr><td>Your height:</td><td colspan="2">Feet / inches</td><td>cm</td><td>Your weight:</td><td colspan="2">Stones / lbs.</td><td>kg</td></tr>
<tr><td rowspan="2">Your Religion:</td><td>C of E</td><td>Catholic</td><td colspan="2">Other Christian (state)</td><td>Buddhist</td><td>Hindu</td><td>Muslim</td></tr>
<tr><td>Sikh</td><td>Jewish</td><td colspan="2">Jehovah's Witness</td><td>No religion</td><td colspan="2">Other religion (state)</td></tr>
</table>

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 list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency)						
Are you able to administer your own medicines?	**Yes**	**No – please detail specific issues (e.g. swallowing, opening containers)**				
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?	**Yes / No**
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?	**Yes / No**
Please state any allergies and sensitivities you have:	
Please state any phobias 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 taken?	**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):**		

Your Accessibility Needs

We want to get better at communicating with our patients. We want to make sure you can read and understand the information we send you. If you find it hard to read our letters or if you need someone to support you at appointments, please let us know.

Please tell us what communication requirements you have (e.g. braille, large print, etc.)	

Your physical examination will include having your height, weight and blood pressure taken, and a specimen of urine for testing.

The Consultation will also establish relevant past medical and family history, including:

- ***Medical factors - illnesses, immunisations, allergies, hereditary factors, screening tests, current health***
- ***Social factors - employment, housing, family circumstances***
- ***Lifestyle factors - diet and exercise, smoking, alcohol and drug abuse.***

We routinely offer screening for Hepatitis and HIV as part of the New Patient Health Check. If you are not sure whether you should have this done, discuss with the Nurse or HCA.