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| **For Office Use:**Photo ID [ ] Proof of Residence [ ] Staff Name:……………………….Date:…………………………….  |

 **The Surgery Teynham**

# New Patient Registration Questionnaire

**Please bring 2 forms of identification**

1. ID (driving licence / passport)
2. A letter with proof of address (utility bill, rent agreement, mortgage statement, bank statement etc.)Please note we don’t want to see any letter regarding National Insurance Number.

\*\*\*We accept registrations from only ME9 9—postcode\*\*\*

**To the Patient:**

To register with the Practice, please complete this questionnaire as fully as possible. The information will help the doctor to make an initial assessment of your health which will help in your future treatment.

**Name and Address:**

**Date of Birth**:

 **Home Telephone**: **Mobile: Email:**

**Ethnicity:** Please tick as appropriate

**White :** **[ ]** British [ ]  Irish [ ]  Other Other:

**Black :** **[ ]** Caribbean [ ]  African [ ]  Other Other:

**Asian:** **[ ]** Indian**[ ]** Pakistani [ ]  Chinese Other:

**[ ]** Other

**Mixed:** **[ ]** White + Black Caribbean Other:

 [ ]  White + Black African

 [ ]  White + Asian

 [ ]  Other

**SMOKING**

Do you smoke? Yes / No

If Yes, how many: ……….

Cigarettes per day …………………. Cigars per day...................... Ounces of tobacco per day ……..

How old were you when you started smoking? …………………..

Do you need Smoking Cessation Advice? Yes / No

**EX-SMOKERS**

How old were you when you stopped smoking? **………………………………………..**

How much did you smoke per day? **………………………………………..**

**ALCOHOL**

**How often do you have a**

**drink that contains alcohol?**  Never Less than Monthly Monthly Weekly Daily or almost daily

**How many standard**

**alcoholic drinks do you** 1-2 3-4 5-6 7-8 10+

**have on a typical day**

**when you are drinking?**

**How often do you have**

**6 or more standard** NeverLess than Monthly Monthly Weekly Daily or almost daily

**Drinks on one occasion?**

**Do you have any**

1. Disabilities? Yes / No

(If so please specify) ……………………………….…………………………………………..

1. Sensory Loss? Yes / No

(If so please specify) ………………………………..…………………………………………..

1. Communication needs? Yes / No

(if so please specify) ……………………………………………………………………………..

**FAMILY HISTORY**

Is there any in your family *(father, mother, brother, sister)* before age of 65 have any of these following?

Heart Disease (heart attacks, angina) Yes / No which family member? ………………………………………..

Stroke? Yes / No which family member? ………………………………………..

Cancer? Yes / No which family member? ………………………………………..

Site of cancer? ………………………………………..

**Preferred Pharmacy:**

(We will default this to the Stevens Pharmacy if you don’t have preference)

**MEDICATION**

Please list all the medications, their strength and dose regimen:

**ALLERGIES**

Are you allergic to any substances, medicines or foods? Yes / No

If yes, please give details:

…………………………………………………………………………………………………………………………………

**PAST MEDICAL HISTORY**

Please give details of any hospital treatment as an in-patient:

Please give details of any treatment for any chronic medical conditions

**Are you a carer? Yes** **[ ]  No** **[ ]**

**Do you have a carer? Yes [ ]  No [ ]**

**Do you have social services input? Yes [ ]  No [ ]**

**NHS SUMMARY CARD RECORDS**

The summary care record is an electronic record to give healthcare staff faster, easier access to essential information about you to help provide you safe treatment when needed in an emergency or when the GP practice is closed.

**DO YOU WANT A SUMMARY CARE RECORD?**

I have no objection to a Summary Care Record ⁭ ; I wish to opt out of the Summary Care Record - Please visit [www.nhs.uk/your-nhs-data-matters](http://www.nhs.uk/your-nhs-data-matters) ⁭

**Please bring in a copy of all of your Immunisations, including travel vaccinations**

If you wish to have patient access online for repeat prescriptions, booking appointments and DCRA, please visit at www.patient.co.uk/access or contact the surgery.

Do you want to register online? Yes [ ]  No [ ]

**YOUR NAMED ACCOUNTABLE GP IS DR LAVAN NILAN SASIKETHAN**

**FEMALE PATIENTS**

Date of last smear: Result:

Have you ever had an abnormal smear: Yes [ ]  No [ ]

***\*\****

***I agree that I may be contacted from time to time, via sms with Practice News, advice about my health and/or appointment reminder. Yes*** ***[ ]  / No*** ***[ ]***

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Signature: …….……………………………. Date:…………………………