MOORLAND MEDICAL CENTRE

DYSON HOUSE, REGENT STREET, LEEK, ST13 6LU

Dr J Greig
Dr A Foster
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Tel: 01538 399008
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Dear Sir/Madam

We would like to welcome you to our practice.

Please complete the attached questionnaire and GMS1 registration form and return them to reception along with proof of your personal identity so that we can register you at the practice.

Upon registration at the practice we will invite you to a new patient health screen appointment (20 minutes) so that we are fully aware of your medical history, as it can take up to 8 weeks for your medical records to arrive at the practice.

The date and time of your appointment is:

Date……..

Time……

Please bring a urine specimen along to the appointment. Bottles are available at reception; please ensure you are given one by reception when you make your appointment.

Yours faithfully

Moorland Medical Centre

For practice use only

<table>
<tr><td colspan="2">Patient Name and Address</td><td>Practice computer ID number

Patient NHS number</td></tr>
<tr><td>Identity verified by (initials)</td><td>Date</td><td>Method
Vouching ☐
Vouching with information in record ☐

Photo ID and proof of residence ☐</td></tr>
<tr><td colspan="2">Authorised by</td><td>Date</td></tr>
<tr><td colspan="3">Date Registration created</td></tr>
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Moorland Medical Centre
New Patient Registration Form

Today's Date:

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.

Please complete a separate form for each family member to be registered.

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:					
Names & Ages of Children					
For children aged 5-16 years please state name of school attending					

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 / e cigarettes/tobacco do you smoke in a week?			**Alcohol Consumption** **Please complete alcohol consumption questionnaire at the end of this form**		
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 indicate if you suffer or have suffered from any of the following (please circle) Diabetes — Epilepsy Stoke/TIA — High Blood pressure Angina/Heart attack — Asthma/COPD Cancer — Thyroid Diseases	
Please list any tablets, medicines (incl. over the counter meds) 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)**
Have you any allergies to anything (drugs, medication, nuts etc)	**No**	**Yes – please specify what you are allergic to**

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**		
	Pneumonia		**Influenza Vaccination**			

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:	
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 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 ?			**Yes**	**NO**

Summary Care Records/Sharing Information

The NHS are changing the way your health information is stored and managed.
The NHS Summary Care record is an electronic record of important information about your health.
It will be available to health care staff providing your NHS Care. Leaflets and opt out leaflets will be provided.

Are you happy to have a Summary Care Record?	**Yes**	**No**	**More time required to decide:**
Do you wish to be excluded from patient research projects?	**Yes**	**No**	**More time required to decide**

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:**	

Your physical examination will include having your height, weight and blood pressure taken, and a specimen of urine for testing (it would be helpful if you would bring a specimen with you when coming to the Practice).

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.***

Moorland Medical Centre

Alcohol Consumption Questionnaire

This is one unit of alcohol…


Half pint of "regular" beer, lager or cider


Half a small glass of wine


1 single measure of spirits


1 small glass of sherry


1 single measure of aperitifs

…and each of these is more than one unit

Pint of "regular" beer, lager or cider

Pint of "strong" or "premium" beer, lager or cider

Alcopop or a 275ml bottle of regular lager

440ml can of "regular" lager or cider

440ml can of "super strength" lager

250ml glass of wine (12%)

75cl Bottle of wine (12%)

AUDIT–C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	0 - 2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

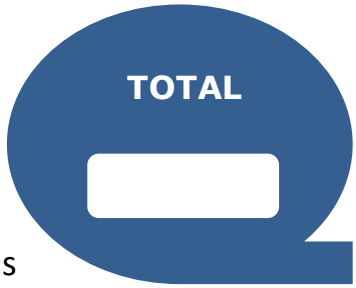
Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

Score from AUDIT- C (other side)

Remaining AUDIT questions

Questions	Scoring system					Your score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 Higher risk, 20+ Possible dependence



TOTAL Score equals
AUDIT C Score (above) +
Score of remaining questions

Please bring this back with your registration form
Thank you

For more information about the services we offer, please refer to your new patient pack or see our website: www.moorlandmedicalcentre.co.uk