RIVERSIDE SURGERY

New Patient Registration Form (Adults 16+)

Please complete this confidential questionnaire. We require one form of photographic ID (i.e. Passport) and one proof of address (i.e. utility bill). If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.

Surname: ……

First Names: ……

Date of Birth: …… Marital Status …….

Gender (please tick) ☐ Male ☐ Female

Home address: ……

……

……

Telephone numbers:

Home: …….. Mobile: ……

☐ **Tick here to confirm we may contact you by SMS (Text)**

☐ **Tick here to confirm we may contact you by Telephone/Answerphone**

☐ **Tick here to confirm we may contact you by Email**

E-mail address: ……

Next of Kin:

Next of Kin's name: ……

Relationship to you: ……

Telephone numbers: ……

Do you smoke: Yes/No If yes, how many per day: ……..

Are you thinking of stopping smoking? If yes, would you like our nurse to contact you about our smoking cessation services? Yes/No

Have you ever smoked: Yes/No If yes, how many per day: ……..

If yes, date of stopping: ……..

Do you drink alcohol: Yes/No If so please answer the following questions: (please circle)

How often do you have a drink that contains alcohol?	Never	Monthly or less	2 – 4 times per month	2 – 3 times per week	4+ times per week
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 9	10+

Based on your answers above how many units of alcohol do you drink per week: ……

(1 pint of beer = 2 units. 1 pub spirit measure = 1 unit. 1 small glass of wine = 1 unit)

Do you or anybody in your family suffer from: (please tick as appropriate & include date of diagnosis if applicable to you, where possible)

	You	Date of Onset	Your family
Asthma			
COPD			
Type 1 Diabetes			
Type 2 Diabetes			
Heart Disease – Under 60			
Heart Disease – Over 60			
Hypertension			
Stroke			
Epilepsy			
Breast Cancer			
Bowel Cancer			
Ovarian Cancer			
Prostate Cancer			
Cancer (please indicate type)			
Hip fracture (mother under 75)			

Have you had/do you have any other major illnesses or operations? (Including dates)

.....
.....

Do you take regular medication prescribed by your doctor or purchased over the counter? Please list:

Name of Medication	Dose

Your Health:

Current Height: …….. Current Weight: ……

Date of last cervical smear: ……. Result: ……..

If pregnant please give estimated date of delivery: ……..

Do you have any allergies: (please specify)

……
……

Your Health:

Current Height: …… Current Weight: ……

Do you take regular exercise: Yes/No

- ☐ Light - Walking
- ☐ Moderate – Gym/Regular sport
- ☐ Heavy – Serious Competitive Sport
- ☐ Avoids even trivial exercise
- ☐ Exercise physically impossible

Nominated Pharmacy:

Please nominate a Pharmacy ……

Specific needs:

Please detail below any specific needs that you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:

……
……

Carers: Do you look after someone? ..... Does someone look after you? ……..

If yes to either of these questions please ask at reception for a Carers Registration Form.

Power of Attorney (POA):

Have you appointed someone as your Power of Attorney ☐ Yes ☐ No

If yes, please give details: …….

Name of POA: ……..

Contact details of POA: …….

Patient Participation Group (PPG)

If you would like to be involved with our Patient Participation Group, which includes receiving communications from the surgery on local health matters, please ensure you have provided your email address or ask Reception for more details.

Patient Ethnic Origin Questionnaire:

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

Ethnic Origin:

- ☐ White British
- ☐ White Irish
- ☐ Other White Background
- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White Asian
- ☐ Other Mixed Background
- ☐ Indian/British Indian
- ☐ Pakistani/British Pakistani
- ☐ Bangladeshi/British Bangladeshi
- ☐ Other Asian Background
- ☐ Black Caribbean
- ☐ Black African
- ☐ Other Black Background
- ☐ Chinese
- ☐ Other Ethnic Group
- ☐ Not stated
- ☐ Do not wish to give ethnicity

Religion:

- ☐ Church of England
- ☐ Catholic
- ☐ Buddhist
- ☐ Hindu
- ☐ Muslim
- ☐ Sikh
- ☐ Jewish
- ☐ Jehovah's Witness
- ☐ Other Christian (Please state……)
- ☐ Other religion (Please state……)
- ☐ No religion

Language – your main or 1st language:

- ☐ English
- ☐ Hindi
- ☐ Guajarati
- ☐ Urdu
- ☐ Bengali
- ☐ Punjabi
- ☐ Polish
- ☐ Ukrainian
- ☐ Spanish
- ☐ German
- ☐ French
- ☐ Other ……

Admin Use Only:

Name of receptionist:

Date of registration:

Registering GP: