

# Twin Oaks 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			
If returning from Armed Forces:		Your Service or Personnel Number		Your Enlistment Date			
Your height:	Feet / inches	cm	Your weight:	Stones / lbs.	kg		
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 1 <sup>st</sup> language Spoken / Understood: (select one)		English	Hindi	Gujurati	Urdu	Bengali /Sytheti	Punjabi
Polish	Ukrainian	French	German	Spanish	Other: (Please Specify)		
<b>Smoking, Alcohol Consumption and Exercise:</b>							
Are you currently a smoker?		Yes	Have you ever been a smoker?		Yes	No	
If so, how many cigarettes / cigars / tobacco do you smoke in a week?			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:			

It is a government priority to address the issue of illness associated with increasing alcohol consumption, and all GP practices have been asked to take part in a survey to screen newly registered patients over the age of 16, with regards to the amount of alcohol they consume on a regular basis. We would therefore ask you to complete the following survey as part of the registration process.

How much alcohol do you drink in a week (Units)? <i>(One unit = 1 small glass of wine, a single measure of spirits, or 1/2 a pint of beer)</i>					
MEN: How often do you have EIGHT or more drinks on one occasion? WOMEN: How often do you have SIX or more drinks on one occasion?					
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	
How often during the last year have you failed to do what was normally expected of you because of drinking?					
Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?					
No	Yes, on one occasion		Yes, on more than one occasion		
Your Medical Background:					

Do you have any medical problems at present?						
Please list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency)						
Known Allergies						
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		

<b>Specific Needs:</b>		
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:	<u>Person Cared For Contact Details:</u>	
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.	<u>Carer Contact Details:</u>	
	<u>Signed:</u>	<u>Date:</u>
Do you have a "Living Will" (a statement explaining what medical treatment you would not want in the future)?	Yes / No	If "Yes", please let us have a copy to keep in your medical records
		Copy Attached      Yes      No
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:

<b>Women only:</b>				
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):		

### **Summary Care Record & Hampshire Health Record**

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 nationally. The Hampshire Health Record is a locally combined electronic health record, bringing together information in your health records from different parts of the NHS in Hampshire.

An information pack has been provided. If you do not complete the following questions we will assume that you are happy to have a Summary Care Record and Hampshire Health Record.

Are you happy to have a Summary Care Record?	Yes	No	More Time Required to Decide
Are you happy to have a Hampshire Health Record?	Yes	No	More Time Required to Decide

It is planned that information about patients and the care they receive will be shared, in a secure system, and information about the Health & Social Care Information Centre (HSCIC) is also provided in the information pack provided.

If you do not complete the following questions we will assume that you are happy for your personal confidential data to be used by HSCIC.

Are you happy to have your personal confidential data (PCD) leave the GP Practice for use by HSCIC	Yes	No	More Time Required to Decide
Are you happy to have your personal confidential data (PCD) leave the HSCIC, ie data gathered from any health/social care setting (eg GP data PLUS hospital data, etc)	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 complete the Practice Patient Participation Group Application Form enclosed in the new patient registration pack.

Patient Signature:		Signature on behalf of Patient:	
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*Please make an appointment for your new patient medical. 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 illnesses, immunisations, allergies, hereditary factors, screening tests, current health, diet and exercise, smoking, alcohol consumption, and any other relevant information about your health.*

**Thank you for completing this form**