New Patient Registration Form

Welcome to Guildhall Walk Healthcare Centre

This form has been designed to help your new GP get to know you and your medical history. The information you provide will be handled confidentially by your GP but if you are concerned about any of the questions please leave them blank. A member of staff will be happy to discuss any queries you have.

PERSONAL DETAILS:

Title:		Address:	
Surname:			
Forename:			
D.O.B:			
Home Tel:			
Mobile Tel:		Postcode:	
Work Tel:		Occupation:	
Status:	Single Married Separated Divorced Widowed In Relationship		
Sexual Orientation:		Do not wish to disclose	

Next of Kin:		Relationship:		Contact Tel No:	
Address:					

DETAILS OF PREVIOUS GP:

Practice Name		
Address:		
Street		
Town / Post Code		
Telephone Number		
Usual Doctor		
How long were you registered with the practice?		

PLEASE COMPLETE FOR ALL PATIENTS UNDER 16 YEARS:

Accompanied today by:	
Name of school:	

ETHNICITY: (Please tick one of the following)

Asian or Asian British	**Mixed**	**Other Ethnic Group**
☐ Bangladeshi ☐ Indian ☐ Pakistani ☐ Other Asian background Please State: **Black or Black British** ☐ African ☐ Caribbean ☐ Other Black background Please State:	☐ White & Asian ☐ White and Black African ☐ White & Black Caribbean ☐ Any other mixed background Please State: **White** ☐ British ☐ Irish ☐ Any other White background Please State:	☐ Chinese ☐ Middle Eastern ☐ Any other ethnicity Please State: ☐ I do not wish to disclose my ethnic origin **First spoken language:**

<u>HOW DID YOU FIND OUT ABOUT US</u>: (Please tick one of the following)

☐ Referred by my GP
☐ Recommended by a friend or relative
☐ Chosen on NHS Choices
☐ Website/Search engine
☐ Local promotion/Information leaflet
☐ Advertisements (please specify) ____

<u>GENERAL HEALTH INFORMATION:</u>

Height:	Weight:	Blood Pressure:

DISABILITY:

	YES/NO	**If so, please give details?**
Do you have a disability or long term condition?		
Do you have a carer?		
Are you a carer?		

PAST MEDICAL HISTORY:

	YES/NO		YES/NO
Heart Disease		Epilepsy	
Stroke		Mental Illness	
Diabetes		HIV	
High blood pressure		Thyroid	
Asthma		Other	
Previously been in hospital? Date & Diagnosis			
Known Allergies			

FAMILY HISTORY: (Parents, brothers & sisters)

	YES/NO	If yes please give brief details	Age at first occurrence	
			Under 60	Over 60
Heart Disease				
Stroke				
High blood pressure				
Diabetes				
Breast Cancer				
Ovarian Cancer				
Bowel Cancer				
Other				

SMOKING:

☐ I am a current smoker	How many per day
☐ I have never smoked	
☐ I am an ex-smoker	Approximate Date of Giving Up

ALCOHOL:

On average, how many units of alcohol a week do you drink per week? (1 unit = half pint beer, 1 glass wine, 1 spirit shot)	

EXERCISE:

In an average week how often do you exercise?		
☐ No regular exercise	☐ More than twice a week	☐ Once or twice a week

WOMEN:

Are you on any form of contraception? If so, please state:			
Date of most recent cervical smear:		Result of smear:	
If age 50-65, date of last mammogram:		HPV vaccinations:	

CURRENT MEDICATIONS:

Taking medication:	€ Yes € No	Allergic to medication:	€ Yes € No
Details:		Details:	

FOR OFFICE USE ONLY	
Proof of Identity	□ Passport □ Driving licence □ Identity card □ Other
Proof of Address	□ Utility Bill □ Tenancy Agreement □ Bank Statement □ Other