New Patient Registration Questionnaire

It can take several weeks to obtain your original notes, and any information you can provide will assist the doctors and nurses in assessing your needs and offering you appropriate healthcare.

Please bring photo ID and proof address with you when returning this form.

Title:	Mr / Mrs / Miss / Ms / Other		
Surname:			
First name:			
Date of birth:			
Home Telephone:			
Mobile Telephone:			
Email:			
Preferred Method of Contact:	SMS [ ] / Letter [ ] / Email [ ] Other [ ] *please note*: ……		
I consent to the practice contacting me for the purposes of health promotion & for appointment reminders - I agree to advise the practice if my mobile number changes or if this is no longer in my possession.			
Signature:		Date:	

Ethnic Origin:	
Main Language:	
Would you like to be a member of our patient participation group (PPG):	YES / NO

Next of Kin / Details of whom we may contact in an Emergency:	
Name:	
Telephone Number:	
Relationship to you:	

Carers & those with Carers:	
Burwell Surgery keeps a register of patients who care for an elderly, infirm or disabled relative or friend and those requiring the help of a carer; this will enable us to offer appropriate help and advice.	
Do you consider yourself the main carer for an elderly, infirm or disabled relative or friend?	YES / NO
Do you rely on the help of a friend or relative to enable you to continue living at home?	YES / NO
Carer's Name / Person Cared for:	
Address of Carer / Person Cared for:	
Telephone Number:	

Relationship to you:	
Any further details that you think are helpful:	

Permission for Named Person:	
Due to my medical condition / language barrier, I give permission to the person named below to discuss my medical needs with Burwell Surgery.	
Title:	Mr / Mrs / Miss / Ms / Other
Surname:	
First name:	
Relationship:	

Record Sharing:		
You have two choices which allow you to control how your record is shared. You can change these choices at any time by letting the relevant practice or service know.		
SHARING OUT	This controls whether your information recorded at this practice or service can be shared with other healthcare services.	YES / NO
SHARING IN	This determines whether or not this practice or service can view information in your record that has been entered by other services who are providing care for you, or who may provide care for you in the future.	YES / NO

Online Services:	
Patients over 16 can now make GP appointments and request prescriptions online. Anyone wishing to use this service **must** have a photo ID and an email address.	
Email Address:	
ID Provided:	Passport [ ] / Driving Licence [ ] / Other [ ]

Lifestyle:			
Our practice is here to support you in all areas of your health therefore providing us with information about your lifestyle would be beneficial to us. Please complete as much of the below as possible.			
Height:		Weight:	
Smoking Status:			
Are you a current smoker:	YES / NO		
Ex-Smoker:	YES / NO	Approx. quit date:	
Never Smoked:	YES / NO		
If you are a smoker and would like help or advice on how to stop, our nurses can help you - Would you like help to quit:			YES / NO

Alcohol Consumption:		
How often did you have a drink containing alcohol in the past year?	**0** - Never **1** - Monthly or less **2** - Two to four times a month **3** - Two to three times per week **4** - Four or more times a week	
How many drinks did you have on a typical day when you were drinking in the past year?	**0** - 1 or 2 **1** - 3 or 4 **2** - 5 or 6 **3** - 7 to 9 **4** - 10 or more	
How often did you have six or more drinks on one occasion in the past year?	**0** - Never **1** - Less than monthly **2** - Monthly **3** - Weekly **4** - Daily or almost daily	

Medication:

If you take any medication regularly we will require you to see a GP before we can issue you any of these. Therefore please ensure you have enough medication to see you through from your previous surgery. The receptionist can assist you in booking this appointment.

If you have previously nominated a pharmacy this will be removed from your record.

How would you like to collect your prescriptions:

I am a **Dispensing** patient *(Medications collected from surgery)*	Green paper prescription from the **Surgery** *(Green paper to take to any pharmacy)*

Electronic prescription sent to: *(new nomination)*

Allergies:

Any allergies or reactions? (e.g. to: medications, medical dressings, vaccinations or foodstuffs):

Family History:

Have any members of your family suffered from the following:
(if YES, please state which family member)

Heart Disease	YES / NO	
Stroke	YES / NO	
Diabetes	YES / NO	

Medical History:
Have you had any operations? Do you have any medical conditions?

Other family members living in the household:	
Name:	
Date of Birth:	
Name:	
Date of Birth:	
Name:	
Date of Birth:	
Name:	
Date of Birth:	
Name:	
Date of Birth:	

Office Use Only:			
ID seen by:			
Form checked by:		Date:	
Entered onto S1 by:		Date:	