

2	Looking After Someone	
	Are you looking after someone? Let us know if you are looking after someone who is ill, frail, disabled or has mental health and/or emotional support needs, or substance misuse problems.	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Is someone looking after you? Let us know if a family member, friend or neighbour looks after you. If yes, they are your carer. You are welcome to invite your carer to accompany you to visits at the practice.	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Carer's name :	Relationship to you:
Address of carer :		
Telephone number of carer :		

3	Are You Currently Employed?			
	If so please specify whether :	<input type="checkbox"/> Full-time	<input type="checkbox"/> Part-time	<input type="checkbox"/> Self-employed
	If you are not employed, please indicate which best describes you:			
	<input type="checkbox"/> Retired	<input type="checkbox"/> Student	<input type="checkbox"/> Housewife/ Homemaker/House husband	<input type="checkbox"/> Unemployed
	<input type="checkbox"/> Other <i>Please state:</i>			
	If returning from the Armed Forces please state which below: Comments:			
<input type="checkbox"/> Army	<input type="checkbox"/> Royal Navy	<input type="checkbox"/> Royal Air force		

Alcohol

Alcohol consumption is measured in units, which is explained in the diagram below

This is **one unit**...



Half pint of regular beer, lager or cider



One very small glass of wine



One single measure of spirits



One small glass of sherry



One single measure of aperitifs

...and each of these is **more than one unit**...



2

A pint of regular beer, lager or cider



3

A pint of premium beer, lager or cider



1.5

Alcopop or a can/bottle of regular lager



2

440ml can of premium lager or strong beer



4

440ml can of super strength lager



2

175mm glass of wine



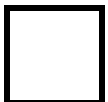
9

Bottle of wine

Please have a look at the above diagram and then answer the questions on the next page.

Total AUDIT Score (Questions 1 – 10):

Questions about your Alcohol Consumption	Scoring System					Your score
	0	1	2	3	4	
1. 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	
2. How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
3. 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	
If your total score for the above 3 questions is 4 or less, then you do not need to complete the questions below						
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	
5. 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	
6. 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	
7. 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	
8. 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	
9. 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	
10. 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.

7	Women Only	What is the date of your last Smear test? (Also known as a PAP or Cervical smear)		Date:	Result:
	Was this at your GP Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please specify who processed your Smear test :		<input type="checkbox"/> NHS <input type="checkbox"/> Private <input type="checkbox"/> Abroad
	Date of last Mammogram (if applicable):				
	Number of pregnancies (include miscarriages & terminations) (If applicable)				
	Do you wish to see a doctor in this Practice for contraceptive services (including the pill, coil or cap)?				

8	Your Medical Background				
	Are there any serious diseases that affect your parents, brothers or sisters? Tick all that apply and state family member:				
	<input type="checkbox"/> Diabetes Who:	<input type="checkbox"/> Asthma Who:	<input type="checkbox"/> Thyroid disorder Who:	<input type="checkbox"/> Stroke Who:	<input type="checkbox"/> COPD Who:
	<input type="checkbox"/> Heart Attack under age of 60 Who:	<input type="checkbox"/> Cancer (Specify type) Who:	<input type="checkbox"/> High Blood pressure Who:	Any other important family illness. Please state:	Who:
Do you suffer from any of the following chronic conditions?					
Chronic condition	Date of diagnosis	Medicines you are currently taking		Staff use only	
Diabetes Mellitus Type I				X40J4	
Diabetes Mellitus Type II				X40J5	
Stroke				XaEGq	
Ischaemic Heart Disease				XE2uV	
Hypertension				XE0Ub	
Emphysema				H32..	
Chronic Bronchitis				H31..	
Asthma				H33..	
Chronic Kidney Disease				X30In	
Depression				XaB9J	
Schizophrenia				Eu20z	
Bipolar Disorder				X00SM	
Other (please state):					

Please state any allergies and sensitivities you have to medicines, food & dressings:			
Please state any mental disabilities you have:			
Are you able to administer your own medicines?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If no</i> please give details, e.g. swallowing or opening containers:	
What long term medical conditions have you had?		Date of Diagnosis:	
What operations or serious injuries have you had?		Date of operations or injuries:	
Please list any tablets, medicines or other treatments you are currently taking / undertaking not already mentioned:			
Name of medication?	What condition is it for?	How many do you take and how often?	What is the dose/strength?

9	Sharing Your Medical Record	
	<p>Medical Record Sharing: Allows your complete GP medical record to be made available to authorised healthcare professionals involved in your care. You will always be asked your permission before anybody looks at your shared medical record.</p> <p>If you do want to share your GP record tick here: <input type="checkbox"/></p> <p>If you do not want to share your GP record tick here: <input type="checkbox"/></p>	
	<p>Summary Care Record: Contains details of your key health information – medications, allergies and adverse reactions. They are accessible to authorised healthcare staff in A&E Departments throughout England. You will always be asked your permission before anybody looks at your Summary Care Record. Ask your GP about the optional ‘Additional information’ choice.</p> <p>If you do want to have a Summary Care Record created tick here: <input type="checkbox"/></p> <p>If you do not want to have a Summary Care Record tick here: <input type="checkbox"/></p>	

10	Patient Participation Group (PPG)	
	<p>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.</p> <p>If you are interested in getting involved in the PPG, please tick yes in the box below and we will contact you with further details.</p>	
	<p>Yes I am interested in becoming involved in the PPG <input type="checkbox"/></p>	<p>No I am not interested in becoming involved in the PPG <input type="checkbox"/></p>

11	Online Services	
	<p>You can now do the following online or via the SystemOnline app:</p> <ul style="list-style-type: none"> Book and cancel appointments, order repeat prescriptions, view your Detailed Medical Record. <p>IT WILL BE YOUR RESPONSIBILITY TO KEEP YOUR LOGIN DETAILS AND PASSWORD SAFE AND SECURE. IF YOU KNOW OR SUSPECT THAT YOUR RECORD HAS BEEN ACCESSED BY SOMEONE THAT YOU HAVE NOT AGREED SHOULD SEE IT, THEN YOU SHOULD CHANGE YOUR PASSWORD IMMEDIATELY.</p>	
	<p>Yes I'd like to register for online services <input type="checkbox"/></p>	<p>No I don't want to register for online services <input type="checkbox"/></p>
	<p>We can now send your prescriptions electronically to the pharmacy of your choice. If you would like us to do this, please give the name and location of the pharmacy here:</p>	

12	Other Information	
	<p>Do you have a “Living Will” or “Advanced Directive”? (A statement explaining what medical treatment you would not want in the future)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>If “Yes”, can you please bring a written copy of it to your first appointment?</p>
	<p>Have you nominated someone to speak on your behalf (<i>e.g. a person who has Lasting Power of Attorney</i>)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>If “Yes”, please state their</p> <p>Name:</p> <p>Address:</p> <p>Phone number:</p>

13	<p>NHS (Charges to Overseas Visitors) Regulations 2015 Self Declaration</p> <p>I am a British resident and entitled to full NHS care <input type="checkbox"/></p> <p>I hold a non-UK issued European Health Insurance Card (EHIC) <input type="checkbox"/></p> <p>I hold an S1 form (entitlement to health care in another European Economic Area country for a limited duration) <input type="checkbox"/></p> <p>For more information on your entitlement to NHS care and charges which may be applicable, please talk to your practice for a leaflet explaining the rules and entitlements for overseas patients accessing the NHS in England.</p>
-----------	---

14	<p>NHS Health Check for patients aged 40-74 years old (“Health M.O.T”)</p> <p>The NHS Health Check is a health check-up for adults in England aged 40-74. It is designed to spot early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia. As we get older, we have a higher risk of developing one of these conditions. An NHS Health Check helps find ways to lower this risk.</p> <p>If you are in the 40-74 age group without a pre-existing condition and you have not had a free NHS Health Check for the past five years you are eligible for an appointment.</p> <p>Please tick if you would like the surgery to contact you for a free NHS Health Check appointment <input type="checkbox"/></p>
-----------	---

CHECKLIST

Thank you for completing this form. Please check you have completed all sections where possible.
Please ensure that you bring the following with you to the surgery to complete your registration:

1. **Completed & Signed New Patient Registration Questionnaire** (this form!)
2. **Completed & Signed GMS1 Form**
3. **Photo Proof of ID** - e.g. Passport, Photo Driving License or Photo ID card
4. **Proof of Address – *Must be in your name and dated within the past 3 months***
 – *Provided in one of the following:* Bank statement, Utility Bill (Gas, Electricity, Water), Council Tax, Tenancy Agreement or Landline Phone Bill (Mobile phone bills are not accepted)
5. If possible, your **Immunisation Records** – usually the Personal Child Health Record (“Red Book”)
6. If possible, your **NHS Card** – usually shows your previous GP and your NHS Number
7. If relevant, your **Repeat Medication Request Slip** from your previous GP

- **Please book a New Patient appointment if you are on any regular medication or have any chronic or significant medical condition**
- **Please request a copy of the Practice Leaflet if you have not already received it. Alternatively you can also find more information on our practice website**
- **I confirm that I have completed this form as accurately and honestly as possible and would like to apply to be registered as a patient at this practice**

13	Signature	Date:
	Patient signature:	Signature if signing on behalf of patient:

OFFICE USE ONLY	Need Appt? <input type="checkbox"/> Yes <input type="checkbox"/> No	Need Etoh Advice? <input type="checkbox"/> Yes <input type="checkbox"/> No	Staff Initials:
Photo ID	<input type="checkbox"/> Passport	<input type="checkbox"/> Driving licence	<input type="checkbox"/> Identity card <input type="checkbox"/> Other
Proof of Address	<input type="checkbox"/> Utility Bill	<input type="checkbox"/> Tenancy Agreement	<input type="checkbox"/> Bank Statement <input type="checkbox"/> Other
Nominated GP	<input type="checkbox"/> Patient advised		<input type="checkbox"/> Patient not advised (add reminder to record)