New Patient Registration/Data Form

WELLINGTON
Medical Practice

Please complete this confidential questionnaire

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.

Today's Date:

Full Name:				**Telephone Number:**	
Mr / Mrs / Miss / Ms / Other				**Work Number:**	
Address and Postcode:				**Mobile Number:**	
				E-mail Address:	
				NHS Number: (If Known)	
				Town & Country of Birth:	
Date of Birth:	**Gender:**	**Male:**	**Female:**	**If applicable, date you first came to live in Britain:**	
If returning from Armed Forces:	**Your Service or Personnel Number**			**Your Last Date of Enlistment**	
Your Height:	**Feet / inches**	**cm**	**Your weight:**	**Stones / lbs.**	**kg**

Your Ethnic Origin: (select one)	**White (UK)**	**White (Irish)**	**White (other)**
Caribbean	**African**	**Asian**	**Other mixed Background**
Indian / Brit Indian	**Pakistani / Brit Pakistani**	**Bangladeshi / Brit Bangladeshi**	**Other Asian Background**
Other Black Background	**Chinese**	**Other**	**Ethnic Category not stated**

Your main or 1st language Spoken / understood: (select one)		**English**	**Hindi**	**Gujurati**	**Urdu**	**Bengali / Sytheti**	**Punjabi**
Polish	**Ukrainian**	**French**	**German**	**Spanish**	**Other (please specify)**		

Smoking and Alcohol Consumption					
Are you currently a smoker?	**Yes**	**No**	**Have you ever been a smoker**	**Yes**	**No**
If so, how many cigarettes / cigars / tobacco do you smoke in a day?					
If you are a smoker and want to stop, please ask for information about smoking cessation services					

Alcohol:					
	0	1	2	3	4
How often do you have 8 (men) / 6 (women) or more units of alcohol on one occasion?	Never	Less than Monthly	Monthly	Weekly	Daily or almost Daily
In the last year how often have you not been able to remember what happened when drinking the night before?	Never	Less than Monthly	Monthly	Weekly	Daily or almost Daily
In the last year how often have you failed to do what was expected of you because of drinking	Never	Less than Monthly	Monthly	Weekly	Daily or almost Daily
Has a relative / friend / doctor / health worker been concerned about your drinking or advised you to cut down	Never	Less than Monthly	Monthly	Weekly	Daily or almost Daily

Your Medical Background:		
What illnesses have you had & when?		
What operations have you had and when?		
Do you have any medical problems at present?		
Please list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency)		
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 OVER age of 60	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	

Specific Needs: 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 or 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		
Do you have a "living Will" (a statement explaining what medical treatment you would not want in the future)?	Yes /No	If "Yes", can you please bring a written copy of it and place in the blue box in the reception area.
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:

Women Only:				
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)		
Do you wish to see a doctor in this practice for contraceptive services?			Yes	No

Summary Care Records 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. An information pack has been provided.			
Are you happy to have a Summary Care Record	Yes	No	More time required to decide

You may be asked to have your height, weight and blood pressure taken.

Receptionist Signature

Thanks you for completing this form

For more information about services we offer, please refer to your copy of our practice leaflet, or see our website:
Website:www.wellingtonmedicalpractice.co.uk