Please provide ID evidence i.e. Birth Certificate, Passport, Driving License, Utility Bill.

Please return this form to a member of the reception team who will make an appointment for your new patient health check.

Patient registration and health questionnaire

Title: (Mr, Mrs, etc.)		**Date of birth**	
Forename(s)			
Surname		**Previous surname**	
Calling name		**Occupation**	
Current address			
Home phone number		**Mobile phone number**	
Email address			

NHS number	
Previous address	
Previous GP	
Have you been registered here previously? If yes, please give dates.	
Have you moved to the UK from abroad? If yes, give date of arrival in the UK.	
Next of kin details: **Title:** **Surname:** **Forename:** **Relationship:** **Address:** **Telephone numbers:**	
Armed Forces veterans' service: **Dates of service:** **Discharge date:** **Address prior to serving:**	
Special circumstances:	Please tick if any of the following apply: I have a carer I am a carer Asylum seeker Housebound Live in a nursing home Live in a residential home Live in a community psychiatric home Live in a children's home

Height		**Weight**	
Allergies		**Disabilities**	
Are you: **Registered blind or partially sighted** **Registered deaf** **Registered disabled**		Please state which of these apply:	
Please state your ethnicity			
Do you have any drug allergies? ***Please include known reactions***			
Do you have any other allergies? ***Please give as much detail as possible***			
Do you suffer from any of the following: **Heart disease** **Hypertension** **Asthma** **Diabetes** **COPD** **Chronic kidney disease** **Epilepsy** **Stroke** **Cancer**		Please state which of these apply and give date of last review:	
Do you have any other serious or chronic illness?		Please explain:	
Do you have a family history of: **Diabetes** **Heart disease** **High cholesterol** **Heart attack** **Stroke** **Cancer**		Please give details including relationship, illness and age at diagnosis if known:	
Have you had any significant injuries or major operations?		If yes, please give details:	
Smoking status – Are you: **A current smoker** **An ex-smoker** **A non-smoker**		If a current or ex-smoker, please give details of how many you smoke or smoked per day. If you are an ex-smoker please give the date you stopped (month/year).	
Smoking cessation advice is available. Would you like further information?		If yes, please ask at reception or see our website for details.	
How many units of alcohol do you drink on a typical day when you are drinking? (1 unit = ½ a pint or a small glass of wine or a single pub measure of spirits)		Please tick which applies: 1-2 3-4 5-6 7-9 10+	

How often have you drunk more than 8 units (men) or 6 units (women) on a single occasion in the past year?	Please tick which applies: Never Daily Weekly Monthly Less often than monthly

Alcohol scoring system	0	1	2	3	4	Score
How often do you drink alcohol	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when drinking?	1-2	3-4	5-6	7-9	10+	
How often have you drunk more than 8 units (men) or 6 units (women) on a single occasion in the past year?	Never	Less often than monthly	Monthly	Weekly	Daily or almost daily	

Advice is available if you would like to reduce your alcohol intake	Please ask at reception or see our website for details.		
Current medication	If possible, attach a copy of your repeat prescription list.		
Medication	Dosage	Repeat	Quantity remaining

Females only:	
Date of last cervical smear	
Contraception used	
Over 65s:	
Have you had a pneumonia vaccine in the last 10 years?	
Have you had a flu vaccine this year?	
Please use this space to give any other information you feel is appropriate:	
PATIENT DECLARATION	
I confirm that, to the best of my knowledge, the information I have provided is accurate and correct.	
Signature	
Print name	
Date	