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Beacon House, Long Lane, Coalville, LE674DR

NEW PATIENT REQUEST TO JOIN PRACTICE LIST

Please complete and return this questionnaire together with **2** forms of identification.

- medical card *or* passport *or* photo driving license *or* National Identity card
and
- bank/ building society statement *or* utility bill (less than 3 months old) showing home address.

Patient Details:

MR MRS MS MISS MASTER MALE FEMALE DATE OF REQUEST:...../...../.....
 SURNAME:..... PREVIOUS SURNAMES:.....
 FORENAMES:..... PREFERRED FIRST NAME:.....
 DATE OF BIRTH:..... PLACE OF BIRTH:.....
 HOME PHONE NUMBER: MOBILE NUMBER:.....
 WORK NUMBER: EMAIL ADDRESS:.....
 NHS NUMBER (if known):.....
 CURRENT ADDRESS:.....
 POST CODE:.....

WHITE

British
 Irish
 Any other white background

BLACK OR BLACK BRITISH

Caribbean
 African
 Any other black background

OTHER ETHNIC GROUPS

Chinese
 Any other ethnic group

MIXED

White & Black Caribbean
 White & Black African
 White & Asian
 Any other mixed background

ASIAN OR ASIAN BRITISH

Indian
 Pakistani
 Bangladeshi
 Any other Asian background

FIRST LANGUAGE

British
 Other Please state:

HAVE YOU ANY OTHER RELATIVES REGISTERED AT THIS PRACTICE: YES NO

IF YES, WHAT IS THEIR RELATIONSHIP TO YOU?.....

Please help us trace your previous medical records by providing the following information:

PREVIOUS ADDRESS IN UK:.....

PREVIOUS DOCTOR:.....

SURGERY ADDRESS:.....

If you are from abroad:

FIRST UK ADDRESS WHERE REGISTERED WITH A GP:.....

IF PREVIOUSLY RESIDENT IN UK, DATE OF LEAVING:.....

DATE YOU FIRST CAME TO LIVE IN UK:.....

If you are returning from the Armed Forces:

ADDRESS BEFORE ENLISTING:.....

SERVICE OR PERSONAL NUMBER:.....

ENLISTMENT DATE: DISCHARGE DATE:

NHS Organ Donor Registration

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death.

(Please tick as appropriate)

Kidneys Heart Liver Corneas Lungs Pancreas Any part of my body

Signature confirming consent to organ donation:.....Date

NHS Blood Donor Registration

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.

Have given blood in the last 3 years YES/ NO

Preferred address for donation (if different from above, e.g. place of work)

Signature confirming consent to inclusion on the NHS Blood Donor Register:..... Date

SIGNATURE OF PATIENT:

SIGNATURE ON BEHALF OF PATIENT:.....PRINT NAME:.....

HEALTH QUESTIONS

1	What is your smoking history? <i>If you are interested in giving up smoking, you can call Resolution on 01509 567766 for free and confidential support from experienced advisors.</i>	Never smoked <input type="checkbox"/> Ex-smoker <input type="checkbox"/> Current smoker <input type="checkbox"/>
2	How many units of alcohol do you drink per week? (1 unit = 1 small glass of wine or ½ pint of beer or 1 small sherry or 1 measure of spirit) (Please also complete Alcohol Questionnaire attached)	
3	Are you a main carer for anyone? <i>A carer, without being paid, provides help and support to a friend, neighbour or relative who could not manage otherwise because of frailty, illness or disability.</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>
4	If so what is your relationship to the person you care for?	Relative <input type="checkbox"/> Neighbor <input type="checkbox"/> Friend <input type="checkbox"/>
5	Please detail any allergies you have	
6	What is your occupation?	

CURRENT REPEAT MEDICATION

The doctor will review your current medication and add to your computer record. When your next prescription is required, visit the surgery and

- Ask for a computer print out of your medication
- Tick the medication you want to order on your computer request slip
- Hand in your slip at the surgery or post to us with a stamped addressed envelope
- Collect your prescription from the surgery 48 hours later

	NAME OF DRUG	STRENGTH e.g. 300mg	DOSE INSTRUCTIONS How many? How often?	WHO STARTED MEDICATION?	DATE MEDICATION STARTED?
1					
2					
3					
4					
5					

When do you need your next supply of medication?.....

FAMILY HISTORY

Has any close family member (grandparent, parent, brother, sister, aunt or uncle) had any of, or suffer from, any of the following?

Problem	Their Relationship to You	Their Age When Illness Started
Heart Attack		
Angina		
Stroke		
Asthma		
Diabetes		

PERSONAL HISTORY

Your full medical record will be sent to us from your last practice in due course. However, in the meantime it is important that we know about the following:

1	Are you diabetic?	Yes/ No
2	Have you ever had a heart attack?	Yes/ No
3	Have you ever had angina?	Yes/ No
4	Have you ever had a Stroke or Transient Ischaemic Attack (TIA) sometimes called a 'mini-stroke'?	Yes/ No
5	Do you take medication for an under-active thyroid gland (Hypothyroidism)?	Yes/ No
6	Are you on treatment for blood pressure (Hypertension)?	Yes/ No
7	Do you have Chronic Obstructive Pulmonary Disease (COPD)? This is a disease requiring regular use of inhalers but is not asthma.	Yes/ No
8	Do you take medication for epilepsy?	Yes/ No
9	Do you have asthma?	Yes/ No
10	Have you recently been diagnosed with cancer or any other serious or life threatening disease not mentioned above?	Yes/ No

Alcohol Questionnaire

For the following Questions please circle the answer which best applies to you:

1 drink = ½ pint of beer / 1 glass of wine / 1 single spirit

1: MEN: How often do you have EIGHT or more drinks on one occasion.
 WOMEN: How often do you have SIX or more drinks on one occasion.

Never Less than monthly Monthly Weekly Daily or almost daily

2: 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

3: How often during the last year have you failed to do what was normally expected of you because of drinking.

Never Less than monthly Monthly Weekly Daily or almost daily

4: In the last year has a relative or friend, or a Doctor or other health worker been concerned about your drinking or suggested you cut down.

No Yes - on one occasion Yes - on more than one occasion

9K16 PN

ACCEPTED APPLICATIONS

If your request to join our practice is accepted and you have answered “No” to all of the above, we simply need to check your height, weight and blood pressure to complete your registration. If you have answered “Yes” to any of the above, we will contact you to advise what needs to be done next. Thank you for your time.

FOR OFFICE USE

Healthcare Assistant	
BP	
Smoker	Never / Ex / Current
Height	
Weight	
BMI	

		Initials
Medication added		
Registered on EMIS		
Letter to patient		