

Welcome to our Practice. We hope that you will be happy with the care we provide for you. Our aim is to provide you with advice on many health issues and, hopefully, to keep you in good health.

Please complete as many of the following questions as you can. This information is **COMPLETELY CONFIDENTIAL** and will help us to provide you with the appropriate medical care for your needs.

DATE OF NEW PATIENT MEDICAL CHECK (where appropriate) _____

(Please bring a sample of urine in a clean container when you attend).

TITLE: (Mr / Mrs / Ms/ Miss) :	Are you a Carer? (Do you look after a relative or friend who is sick, disabled, elderly, has mental health problems or for any other reason) <input type="checkbox"/> Yes <input type="checkbox"/> No
SURNAME:	Do you have a carer yourself? <input type="checkbox"/> Yes <input type="checkbox"/> No
FORENAMES:	Do you have a disability / any special requirements that we need to take into account? <input type="checkbox"/> Yes <input type="checkbox"/> No
D.O.B.	If yes, please give details:
ADDRESS:	
POST CODE:	
GENDER: Male / Female	RELIGION
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Living together <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	<input type="checkbox"/> Buddhist <input type="checkbox"/> Christian <input type="checkbox"/> Hindu <input type="checkbox"/> Jewish <input type="checkbox"/> Muslim <input type="checkbox"/> Sikh <input type="checkbox"/> Other <input type="checkbox"/> None If OTHER please state:
CONTACT TELEPHONE NUMBERS: Home: Mobile: Work:	What is your country of origin? Date of entry into the UK (if not born here)? What is your main spoken language(s)? Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No
OCCUPATION:	Are you a refugee or an asylum seeker? <input type="checkbox"/> Yes <input type="checkbox"/> No
IF A CHILD, NAME OF SCHOOL ATTENDED: (please bring a copy of immunisation records to the surgery)	Which ethnic group do you feel you belong to? WHITE: White British / Irish / Other white MIXED: White & Black Caribbean / White & Black African / White & Asian / Other mixed (please specify)
NAME OF NEXT OF KIN: (please state relationship to you)	ASIAN / BRITISH ASIAN: Bangladeshi / Indian / Pakistani / Other Asian
Telephone No of Next of Kin:	BLACK / BLACK BRITISH: Caribbean/African
Name and address of previous Doctor:	OTHER ETHNIC CATEGORIES: Chinese / any other (please specify)
DO YOU CONSENT TO US CONTACTING YOUR DESIGNATED NEXT OF KIN, SHOULD WE BE UNABLE TO CONTACT YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO	DO YOU CONSENT TO US SENDING YOU SMS TEXT MESSAGES REGARDING OUR SERVICES / APPOINTMENTS? <input type="checkbox"/> YES <input type="checkbox"/> NO

THE ST JAMES PRACTICE – Registration Form

2

FAMILY HISTORY: Do YOU or any of YOUR RELATIVES suffer from the following conditions?

(Please ✓ appropriate boxes below)

CONDITION	FAMILY MEMBER		YOU
	At What age did they have these?	please specify relationship to you and age	
Heart Attack			
Angina			
Stroke / TISA/ Brain Haemorrhage			
Hypertension (high blood pressure)			
Diabetes Type 1 or Type 2			
Epilepsy			
Asthma			
COPD			
Hypothyroidism			
Kidney Disease			
Depression			
Dementia			
Mental Health Problems			
Obesity			
Cancer (please specify)			
Any other diseases			

YOUR PAST MEDICAL HISTORY (please list any serious illness, operations or accidents with dates)

DATE	TYPE OF OPERATION, ILLNESS, ACCIDENT or CONDITION

CURRENT MEDICATIONS (please include any medicines you regularly purchase from the chemist or other retail outlet)

NAME OF MEDICATION	ON PRESCRIPTION	PURCHASED FROM CHEMIST/ SHOP

SMOKING STATUS:

Do you smoke?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If YES - how many per day OR how many grammes of tobacco?	Per day	Grammes
Are you an ex-smoker?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes – when did you stop :		
Are you interested in stopping and being referred to the Smoking Cessation Clinic?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

ALCOHOL:

How many units of alcohol do you consume in one week?

EXERCISE:

Do you take any form of exercise?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
How many times per week do you exercise		
WEIGHT:		HEIGHT:

DIET

Do you eat a healthy balanced diet?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you any special dietary requirements?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If YES please specify:		

VACCINATIONS: When did you last have the following vaccinations?

TYPE OF VACCINATION	DATE
Tetanus	
Typhoid	
Polio	
Hepatitis A	
Hepatitis B	
MMR	
BCG	
Meningitis	
Influenza (only if you are over 65 years of age or in an 'At Risk' group. i.e. CHD, stroke, diabetic, COPD of Asthmatic)	
Pneumonia Vaccine (should be given in you are 65 years or age or over OR in an 'At Risk' group, i.e. CHD, stroke, diabetic, COPD of Asthmatic)	

WOMEN ONLY:

Are you pregnant or could you possibly be pregnant? Yes No

Please state what method of contraception you use _____

If using Depo Provera, when is your next injection due? _____

When and where did you last have a Cervical Smear Test? _____
(if you have a copy of the result, please bring it to the surgery when you attend for your health check)

Have you had any previous abnormal smear results? Yes No

Number of births _____ Number of miscarriages _____ Number of terminations _____

Have you had a hysterectomy? Yes No

If YES please state date and name of hospital _____

Do you take HRT? Yes No

IMPORTANT NOTE:

Contraceptive and HRT pills are not given as repeat prescription items without first having a check up with our Practice Nurse. At that appointment a six month supply will normally be prescribed.

IS THERE ANY OTHER INFORMATION YOU WOULD LIKE TO TELL US THAT WILL HELP US TO PROVIDE YOU WITH THE APPROPRIATE MEDICAL CARE FOR YOUR NEEDS?

.....
.....
.....

Name :

Signature:

Date:

TO BE COMPLETED BY THE PRACTICE NURSE AT YOUR HEALTH CHECK APPOINTMENT

Date of Health Check:		Yes	No
Height		Dietary advice given	
Weight		Exercise advice given	
BMI		Smoking advice given	
Waist Circumference		Alcohol advice given	
Urine		Contraceptive advice given	
BP		BCG Scar seen	
PF (Asthma)		Diet advice given (Fat)	
BM (Diabetics)		Diet advice given (salt)	
Next smear due date:			