THE PENINSULA PRACTICE
New Patient Registration Form

Today's Date:

Please complete this confidential questionnaire (one for each member of the family to be registered with the Practice).

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.

Surname:			Previous Name:		
First name:			Male ☐	Female ☐	Age
Date of Birth:			NHS No:		
Place of Birth:			No of Children:		
Address:					
Post Code:		Telephone No:		Mobile No:	
Email address:			Consent To send Emails: Yes ☐ No ☐		
Occupation:					
Next of Kin:			Relationship:		
Telephone No:			Consent to Send SMS Texts	Yes ☐ No ☐	

Do you suffer from any of the following illnesses?					
Asthma	☐	Cancer - Type	☐	COPD	☐
Diabetes	☐	Epilepsy	☐	Heart Disease	☐
High Blood Pressure	☐	Hypothyroidism	☐	Stroke	☐
If yes to one or more of the above, which one(s) and what was the date of onset?					

Have any close members suffered from any of these illnesses:					
		Relationship to you			Relationship to you
Asthma	☐		Heart disease	☐	
Cancer	☐		**Type of Cancer**	☐	
Stroke	☐		High Blood Pressure	☐	
COPD	☐		Hypothyroidism	☐	
Diabetes	☐		Kidney Disease	☐	
Epilepsy	☐				

Your Medical Background:		
What illnesses have you had & When?		
What operations have you had and When?		
Please list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency)		
The surgery is a dispensing practice and will now dispense these medications to you from our sites. So any pre-set Pharmacies will be removed.		
Are you able to administer your own medicines?	**Yes**	**No – please detail specific issues (e.g. swallowing, opening containers)**

Do you suffer from any allergies? If so please list:	
Are your immunisations up to date?	Yes ☐ No ☐
And what date did you have them?	

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 disabilities you have:	
Please state any 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 to your New Patient Consultation***
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:**

SystmOne is the clinical system that holds your medical records. It has the facility that if you are cared for at another organisation that uses SystmOne ie Community Health they can see your records here and we can see the care you receive there. Can you please choose your sharing options below?			
Do you consent for your GP surgery to share your medical record with other healthcare professionals who are involved in your healthcare?		Do you consent for your GP surgery to see what other healthcare professionals write in your medical record?	
Yes ☐	No ☐	Yes ☐	No ☐

CARER / CARED FOR		
Do you look after someone?	**Yes** ☐	**No** ☐
If yes, who do you care for?		
Does someone look after you?	**Yes** ☐	**No** ☐
If yes, who cares for you?		
Are you housebound?	**Yes** ☐	**No** ☐
Would you like to hear from other organisations that can support you?	**Yes** ☐	**No** ☐

Would you like a New Patient Check? All patients are entitled to a New Patient Check with a HCA. However if you have a Chronic Illness please book a New Patient Check at Reception.	**Yes** ☐	**No** ☐
How many units of alcohol do you drink each week? 1 unit is half pint beer, a spirit 25ml measure or a 125ml glass of wine.	**……units**	
Do you have any dietary requirements? i.e. milk free	**Yes** ☐	**No** ☐
Would you like to receive information on Long Acting Reversible Contraception	**Yes** ☐	**No** ☐

SMOKING STATUS		
Do you currently smoke	**Yes** ☐	**No** ☐
If YES indicate how many per day		
Would you like help to stop?	**Yes** ☐	**No** ☐
Have you already given up? Date:	**Yes** ☐	**No** ☐

WEIGHT MONITORING	
What is your Weight?	
(please enter so that your BMI can be calculated)	
What is your Height?	
(please enter so that your BMI can be calculated)	

PLEASE LIST ALL THE MEDICATION YOU ARE CURRENTLY TAKING			

If you are taking any medication, please make an appointment with a Doctor. Please return all unwanted and unused medication to the dispensary and ensure you do not re-order these medications. The Doctors would rather know if you are not taking the medication

ETHNICITY AND FIRST LANGUAGE

What is your Ethnicity?		What is your first spoken language?	

Patient Participation Group

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.
If you are interested in getting involved, please tick the box below and we will arrange for the Practice Patient Participation Group Application Form to be given to you at your initial consultation.

Yes, I am interested in becoming involved in the Practice Patient Participation Group (Please tick the "Yes" Box)	**Yes**

Patient Signature:		**Signature on behalf of Patient:**	

Your physical examination will include having your height, weight and blood pressure taken, and a specimen of urine for testing (it would be helpful if you would bring a specimen with you when coming to the Practice).
The Consultation will also establish relevant past medical and family history, including:

- ***Medical factors - illnesses, immunisations, allergies, hereditary factors, screening tests, current health***
- ***Social factors - employment, housing, family circumstances***
- ***Lifestyle factors - diet and exercise, smoking, alcohol and drug abuse.***

Thank you for completing this form

For more information about the services we offer, please refer to your new patient pack or see our website: www.thepeninsulapractice.co.uk