**Cherry Tree Surgery**

**132 Commercial Street**

**Batley, West Yorkshire**

**WF17 5DH**

NEW PATIENT REGISTRATION QUESTIONNAIRE PART 1

To enable us to register you with the practice please complete the following questionnaire as fully as possible. We will also ask you to provide evidence of identification, e.g. a passport or photo driving licence, together with proof of residence.

#### Surname: …………………………………………. Forename(s) ………………………………………………………

#### 1 Do you normally live in the UK? Yes 🞏 No 🞏

2 If you do not normally live in the UK how long are you intending to stay? …………………..

3 In what country were you born? ……………………

4 If you are **not** a UK national do you have medical insurance to cover your treatment? Yes 🞏 No 🞏

5 Do you have a form E128? Yes 🞏 No 🞏

The form E128 is used within the European Economic Area (EEA) and applies to workers

 or students (and their families who accompany them) who are posted from one member

 state to another. Patients with an E128 are entitled to full health care from the NHS

6 Are you a refugee who has been given leave to remain in the UK Yes 🞏 No 🞏

7 Are you an Asylum Seeker Yes 🞏 No 🞏

8 What is your first language (if not English) ,,,,,,,,,,,,,,,,,,,,,,,,,,,,

1. How would you describe your ethnicity? Please tick

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| White British **9S10** |  | Any other white background **9S14** |  | Mixed White and Black **9i62**  |  | Mixed – White and Asian **9i5** |  |
|  |  |  |  |  |  |  |  |
| Black British **9s41** |  | Black Caribbean **9S2** |  | Black African **9S3** |  |  Mixed |  |
|  |  |  |  |  |  |  |  |
| British Pakistani **9i8** |  | Pakistani **9S7** |  | Bangladeshi  **9i9** |  | Indian  **9S6** |  |
|  |  |  |  |  |  |  |  |
| Sikh  **9iF8** |  | Any other Asian background  **9iA** |  | Chinese **9iE** |  | Arab  **9iF9** |  |
| Does not want to give Ethnic Group **9SD** |  |  |  |  |  |  |  |

1. Exercising your right to OPT OUT OF THE ELECTRONIC MEDICAL RECORD

If you do not wish your record to be uploaded to the national shared database please ask the Receptionist for the OPT out form.

I declare that the details above are correct.

Signed ……………………………………………………. Date ………………………………………………

**Please turn over**

**Cherry Tree Surgery**

## NEW PATIENT REGISTRATION QUESTIONNAIRE – PART 2

**To be completed by all patients over the age of 12**

PLEASE WRITE CLEARLY IN CAPITALS

|  |
| --- |
| Title and Last Name |
| First Name(s) |
| Male **🞏** Female **🞏** | Date of Birth |
| Address |
| Home Tel No: | Mobile Tel No: |
| Email Address: |
| Nationality: | Work Tel No: |
| Occupation |
| Are you a student? **Yes 🞏 No 🞏**  | If yes, at which college? |
| Name of Next of Kin who can be contacted in the event of an emergency |  |
| Telephone Number of Next of Kin |  |
| Please list any serious illnesses or accidents or operations you have had**Year Illness/accident/operation Hospital** |
| Are you currently under medical care of any sort**? Yes 🞏 No 🞏** If yes, please describe |
| Do you suffer from any allergies? **Yes 🞏 No 🞏** If yes, please describe |
| Are you taking any regular medication? **Yes 🞏 No 🞏** If yes, please describe |

|  |
| --- |
| Has anyone under 60 in your near family suffered from heart disease or had a stroke? **Yes 🞏 No 🞏**   |
| Has anyone under 60 in your near family suffered from diabetes? **Yes 🞏 No 🞏**  |
| Do you smoke? **Yes 🞏 No 🞏** **Never Smoked 🞏**  **Ex-smoker 🞏**If Yes, how many per day do you smoke? \_\_\_\_\_\_\_\_  |
| The Department of Health has asked GPs to try to address the issue of illness associated with increasing alcohol consumption. Practices have been asked to screen newly registered patients aged 16 and over using this simple questionnaire. The information is confidential and will be recorded in your medical record. If you score 5 or more, you may like to pick up one of the leaflets “Units and You” which are available on the table in the in the waiting room and which provide useful information. |

|  |  |  |
| --- | --- | --- |
| **Questions** | **Scoring System** | **Your Score** |
| 0 | 1 | 2 | 3 | 4 |
| How often do you have a drink that contains alcohol? | Never | Monthly or less | 2 – 4 times per month | 2 – 3 times per week | 4+ times per week |  |
| How many standard alcoholic drinks do you have on a typical day when you are drinking? | 1 – 2 | 3 – 4 | 5 – 6 | 7 – 8 | 10+ |  |
| How often do you have 6 or more standard drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |

**Scoring: a total of 5+ indicates hazardous or harmful drinking**

|  |
| --- |
| FOR WOMEN |
| Have you had a cervical smear test?  **Yes 🞏 No 🞏** **If yes please supply:****Date** …………………..**Where Taken** …………………..**Result** ………………….. |
| Have you had a hysterectomy? **Yes🞏 No 🞏** If yes please supply date |
| Are you using any form of contraception? **Yes 🞏 No 🞏**If yes please describe briefly |

Thank you for providing the above information.