MINSTER MEDICAL PRACTICE
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NEW PATIENT REGISTRATION FORM – OVER 16 YEARS OF AGE

Welcome to Minster Medical Practice. Please help the Doctors by completing this questionnaire as fully and as accurately as possible.

PATIENT DETAILS DATE _____

Mr Mrs Miss Ms Other		Surname	
Date of Birth		First Name(s)	
NHS No		Previous Name(s)	
Home Address			
Postcode			
Home Tel No		Mobile Tel No	
Preferred No	Home ☐ Mobile ☐ Other:		
Email Address			
Marital Status		Occupation	
First Language		Country of Birth	

Ethnicity: (Please tick the most appropriate box)	British or Mixed British	Irish
	Indian or British Indian	Chinese
	Pakistani or British Pakistani	Caribbean
	Bangladeshi or British Bangladeshi	African
	White & Black Caribbean	Other Black background
	White & Black African	Other White background
	White & Asian	Other Asian background
	Ethnic category withheld	Other mixed background

NEXT OF KIN DETAILS

NAME		RELATIONSHIP TO YOU
CONTACT NUMBER		
ADDRESS		

PHARMACIES – In order to have your Prescription electronically sent to a Pharmacy please select your preferred pharmacy below.

Co-op Cabourne		Authorised? YES /NO	Co-op Burton Road		Authorised? YES / NO
Co-op St Boltophs (South Park)		Authorised? YES /NO	Co-op Winning Post (Monks Rd)		Authorised? YES / NO
Boots High Street		Authorised? YES /NO	Boots Carlton Centre		Authorised? YES / NO
Tesco		Authorised? YES /NO	Watsons		Authorised? YES / NO
Lloyds		Authorised? YES/NO	Other (please state)		Authorised? YES / NO

SMS/EMAIL CONSENT – On occasion we may wish to contact you via text message or email, for example to send confirmation of appointment date and time or for health related messages.

I ***GIVE*** consent for Minster Medical Practice to contact me via text message or email.	
Signature:	Date:
I ***DO NOT GIVE*** consent for Minster Medical Practice to contact me via text message or email.	
Signature:	Date:

Please remember to update the Practice if you change your telephone number or email address.

NHS PATIENT INFORMATION SHARING – Please find enclosed leaflets for Summary Care Record and Electronic Patient Record Sharing IN and OUT. Please read these fully.

I ***CHOOSE*** to have a NHS Summary Care Record	
Signature:	Date:
I ***DO NOT CHOOSE*** to have a NHS Summary Care Record	
Signature:	Date:

I ***GIVE*** consent for Minster Medical Practice to ***SHARE IN*** my electronic patient record	
Signature:	Date:
I ***DO NOT GIVE*** consent for Minster Medical Practice to ***SHARE IN*** my electronic patient record	
Signature:	Date:

I ***GIVE*** consent for Minster Medical Practice to ***SHARE OUT*** my electronic patient record	
Signature:	Date:
I ***DO NOT GIVE*** consent for Minster Medical Practice to ***SHARE OUT*** my electronic patient record	
Signature:	Date:

HEALTH CHECKS - Health checks are offered to all new patients ***not currently on any repeat medication***.
(Patients with repeat prescriptions will require an appointment with a GP when they are registered)

Would you like to be offered an appointment with our Nurse for a health check?		
New patient health check	Yes (we will contact you)	No

Please provide your current height and weight

Height	Metres	Weight	Kg

SMOKING STATUS – Please tick boxes and complete as appropriate:

Never Smoked		N/A	
Ex – Smoker		Date Stopped:	
Smoker		How many per day?	
		Would you like advice/help to stop smoking?	

ALCOHOL CONSUMPTION – Please circle the most appropriate answer for all 3 questions:

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 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

ARMED FORCES DETAILS

Have you ever serviced in the armed forces?		YES / NO	
Which branch of the armed forces did you serve with?			
If YES are you still a reservist?		YES / NO	
Enlistment date:		Leaving date:	

Minster Medical Practice
APPLICATON FOR INFORMATION TO BE SHARED WITH FAMILY MEMBER

Details of the patient wanting information to be shared:

Patient Surname	NHS Number
Patient Forename	Address
Date of Birth	

Details of the person information to be shared with:

Surname	Forename
Address	Telephone Number
	Relationship to Patient

Declaration: I would like the access below to be given to the person I have listed above I accept that it is my responsibility to inform the practice if I want this access to be changed/ceased. I confirm that the practice will not be breaching my confidentiality by sharing this information with the person shown above and that the access will be in place until I inform the practice in writing of any changes.

Tick whichever of the following statements apply:

☐ I would like the above person to be able to access information about my appointment details, i.e. book appointments, confirm dates/times.

☐ I would like the above person to be able to request medication on my behalf.

☐ I would like the above named person to be given information about my medication

☐ I would like the above named person to be given my test results

☐ I would like any information about my healthcare contained in my medical records to be shared with the above person.

Applicant signature: _____ **Date: _____**

FEMALE PATIENTS – if you use any form of contraception please circle which one:

Coil	Depo Injection	Implant	Oral Pill	Other

If you do use contraception, when was your last check-up/review with GP or Nurse?	Date:
If you have a Coil or Implant, approximately what date was it fitted?	Date:
If you have depo injections when was your last one?	Date:
When was your last smear?	Date:
What was the result of your last smear?	Date:

ALLERGIES

Please list any allergies the patient has:	

MEDICATION

Are you currently taking repeat medication? (Please tick the appropriate box)

Yes	No
If you are currently taking repeat medication, please make sure you have enough supply to last you for a month. You will need to see a Doctor before we are able to issue you with any medication. Please arrange a review before you run out of your current supply.	

PATIENTS AGED 65 AND OVER

Have you had a flu vaccination in the last year?	Yes	No
If no, would you like one this year? (Vaccines are in stock September to March each year)	Yes	No
Have you had a pneumonia vaccination? (only one required)	Yes	No
If no, would you like to be vaccinated?	Yes	No

PATIENTS AGED 70 AND OVER

Have you ever had a shingles vaccination?	Yes	No
If no, would you like to be invited when you are eligible? (Eligibility depends on age at the time of the vaccination)	Yes	No

ADDITIONAL COMMUNICATION REQUIREMENTS – Do you have any specific communication needs? By leaving this section blank we ***WILL NOT*** record alternative communication methods in your record. Please only tick the boxes that apply.

Braille Grade 1		Braille Grade 2	
British Sign Language		Contact via carer/third party	
Verbally (telephone) only		Email only	
Text message only		Large print font	
Interpreter	(Please state language)		
Other	(Please state other)		

FAMILY MEDICAL HISTORY

Has the patient's parent(s) or sibling(s) suffered from any of the problems listed below – please circle the family member and write the age at which they were diagnosed.

Asthma	Father / Mother / Sister / Brother	Age:
Blood Pressure (High / Low)	Father / Mother / Sister / Brother	Age:
Cancer	Father / Mother / Sister / Brother	Age:
Diabetes	Father / Mother / Sister / Brother	Age:
Heart Attack	Father / Mother / Sister / Brother	Age:
Stroke	Father / Mother / Sister / Brother	Age:

MEDICAL HISTORY – Please tick if you have a history of any of the following:

Cancer		Depression or Mental health problems	
Dementia or Alzheimer's		Kidney Disease	
Hypertension (High blood pressure)		Heart failure, Coronary Heart Disease or Atrial Fibrillation	
Asthma or COPD		Learning Difficulties	
Diabetes		Thyroid Disease	
Epilepsy		Stroke or Transient Ischemic Attacks	
If they have any other history, important illnesses or disabilities not mentioned above, please give details here (include diet requirements)			

I wish to apply for online access to my medical records for	
I would like my username and password to be sent to me via: ***EMAIL*** ***PRINTED (This will need to be collected)*** ***TEXT MESSAGE*** ***(Please circle your choice)***	
Signature:	Date:

"Do you look after someone who wouldn't be able to get by on their own?"

Who is a Young Carer?

Anyone under the age of 18 who cares for a friend or family member (who could not cope without their help) is a Carer. Reasons someone might need help could be: Illness, Disability, Old Age, a Mental Health Problem or an Addiction.

Why Join the Practice Carers Register?

We know that while rewarding, being a Carer can be hard. In order to provide help and support to Adult and Young Carers we need Carers to Self-Identify. This means that the Practice can offer you help and information both in terms of additional NHS care and signposting to Carer charities.

I look after someone who wouldn't be able to get by on their own

YOUR DETAILS (Carer)

Name	
Date of Birth	
Address	
Postcode	
Telephone Number	
Name of your GP Surgery	

Please tick this box if you are in receipt of **Carer's Allowance** (You will need to provide evidence of this if having a Free NHS Flu Jab) ☐

Please tick this box if you would like the practice to consider your eligibility for a Free NHS Flu Jab ☐

I LOOK AFTER MY .....(Patient Details)

Name	
Date of Birth	
Nature of Illness/Disability	
Name of your GP Surgery	

Anyone can register as a Carer. If you feel that you look after someone who would struggle without your help please complete the form above to *enable us to better support you*.

MINSTER MEDICAL PRACTICE

SUPPORTING YOUNG CARERS

Patient checklist for completing the registration form:

NHS Number (can be obtained from previous GP Practice) ☐

Contact details (address, telephone number and email) ☐

Previous GP details ☐

Proof of address ☐

Photo ID ☐

Return forms to the Practice with proof of address and ID ☐

Practice checklist when patient has requested online access

Photo ID ☐ Please specify type seen: _____

Proof of Address ☐

Email address / Mobile number ☐

Practice checklist when form returned by patient:

Photo ID ☐

Proof of Address ☐

Address within our catchment area ☐

Telephone numbers ☐

NHS Number ☐

Town and Country of birth ☐

Previous GP ☐

Full previous address ☐

SMS consent ☐

Summary Care Record consent ☐

Sharing in and out preferences ☐

New patient health check ☐

Smoking and alcohol status ☐

Checked by (Signed) ……. Date…….

Checked by (Print Name) …….