Wollaton Park Medical Centre
New Patient Registration Form

Please complete this confidential questionnaire filling in all the boxes as appropriate one will be required to be filled in per patient.

If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.

Once completed please return back to reception along with the completed GMS1 Form (purple form) with some photographic ID and proof of address.

Mr / Mrs / Miss / Ms / Other...	Address and Postcode:	Date of Birth:
Full Name:		Gender:

Telephone Number:	Mobile Number:	Work Number:	Email Address:
NHS Number:	Next of Kin:	Next of Kin Contact Number:	Town & Country of Birth:

Marital Status:	Occupation:	Names & Ages of Children:
Other Residents at your home address:		

Your height:	Feet/Inches	cm	Your weight:	Stones/lbs	kg

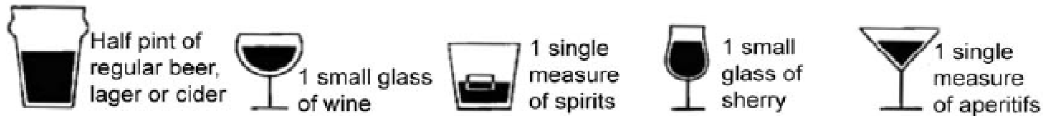
Your religion:	Church of England	Catholic	Other Christian (state)	Hindu	Buddhist	Muslim
	Sikh	Jewish	Jehovah's Witness	No religion	Other religion (state)	

Your Ethnic Origin: (select one)	White (UK) 9i0	White (Irish) 9i1%	White (other) 9i2%	Caribbean 9i3	African 9i4
African 9i4	Asian 9i5	Other mixed back-ground 9i6	Indian/ British Indian 9i7	Pakistani/ British Pakistani 9i8	Bangladeshi/ British Bangladeshi 9i9
Other Asian Back-ground 9ia	Other Black Background	Chinese 9ie	Other 9if	Ethnic Category not stated 9ig	

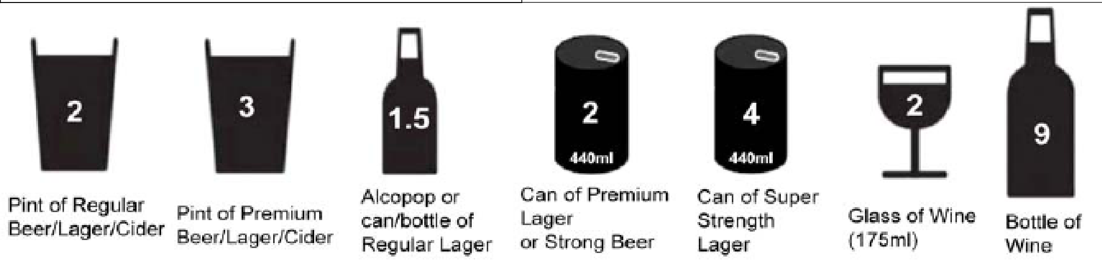
Your main or 1st language Spoken/ Understood	English	Hindi	Gujarati	Urdu	Punjabi	Polish	French	German
	Spanish	Other (please specify)						

Smoking and Exercise:					
Are you currently a smoker?	Yes	No	Have you ever been a smoker?	Yes	No
If so, how many cigarettes/cigars/ tobacco ounces do you smoke in a week?			Would you like information on how to stop smoking?	Yes	No
How often do you exercise?			How long do you exercise for?		

This is one unit of alcohol:



… and each of these are more than one unit:



Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring: **My Score is:**

If you score 5 or more can you please complete the second questionnaire below…..

Questions	Scoring system					Your score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0 – 7 Lower risk, 8 – 15 Make an appointment to see our Health Care Assistants, 16 – 19, Make an appointment to see our Practice Nurses, 20+ Make an appointment to see a GP **My Score is:**

Your Medical Background

Have you had any of the following conditions and when?

Atrial Fibrillation		Heart Disease		Hypertension		Stroke		Diabetes	
Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

High Blood Pressure		Hypothyroidism		Asthma		COPD		Dementia		Depression	
Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

Cancer		Osteoporosis		Mental Health		Learning Disabilities		Rheumatoid Arthritis		Cardio Vascular Disease	
Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

Chronic Kidney Disease		Epilepsy date of last seizure		
Yes	No	Yes	No	Date:

What operations have you had and when?		
Please list any tablets, medicines or other treatments you are currently taking (inc dose & frequency		
Are you able to administer your own medicines?	Yes	No - please detail specific issues (e.g. swallowing, opening containers)

Are there any serious diseases that affect your parents, brothers or sisters (tick all that apply)

Diabetes	Heart Attack	Heart attack under age of 50	Bowel Cancer	Breast Cancer	Asthma
High Blood Pressure	Stroke	Thyroid Disorder	Any other important Family Illness?		

What immunisations have you had? (please tick all that apply)

Diphtheria	Measles	German Measles	Tetanus	Polio	MMR	Whooping Cough
Pre-school booster	Triple vaccine (Diphtheria, tetanus & Pertussis)- 3 doses					

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:	
Do you require the help of a Translator/ Interpreter?	
Please state any allergies and sensitivities you have:	

If you are a Carer, please state the name/address/ phone number of the person you care for:	**Person Cared for Contact Details:**	
If you have a Carer, please state their name/ address/phone number and sign here if you wish us to disclose information about your health to your carer	**Carer Contact Details:**	
	Signed:	**Date:**

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 next GP appointment
Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)	Yes / No
	If 'Yes' can you please bring a written copy of it to your next GP appointment

Women only:						
When was your last smear done?	Date	Was this at your GP's surgery?	Yes	No	Date of last mammogram (if applicable)	Date
What was the result of the smear?		Do you wish to see a doctor in this practice for contraceptive services (including the pill, coil, implant)	Yes	No		
Method of contraception (if used)						

Summary Care Records

The NHS are changing the way your health information is stored and managed.
The NHS Summary Care record is an electronic record of important information about your health.
It will be available to health care staff providing your NHS Care.

Are you happy to have a Summary Care Record?	Yes	No	More time required to decide:

Patient Signature:		Signature on behalf of patient:	

Thank you for completing this form

For more information about the services we offer, please see our Practice leaflet or see our website
www.wollatonparkmedicalcentre.co.uk

Name:
DOB:
Address:
NHS number:

In accordance with The Accessible Information Standard (SCCI 1605 (Accessible Information)) please accept the below as formal notification of my information and communication preferences.

I communicate using (e.g. BSL, deafblind manual):

To help me communicate I use (e.g. a talking mat, hearing aids):

I need information in (e.g. braille, easy read):

If you need to contact me the best way is (e.g. email, telephone):

The Accessible Information Standard (SCCI 1605 (Accessible Information))

Providers of health and adult social care services have new duties to support those who access their services who have sensory impairments and/or learning disabilities. They must:

1. **Identify** the communication and information needs of those who use their service;
2. **Record** the communication and information needs they have identified;
3. Have a consistent **flagging** system so that if a member of staff opens the individual's record it is immediately brought to their attention if the person has a communication or information need;
4. **Share** the identified information and communication needs of the individual when appropriate;
5. **Meet** the communication and information needs identified.

For more information visit: https://www.england.nhs.uk/ourwork/patients/accessibleinfo-2/