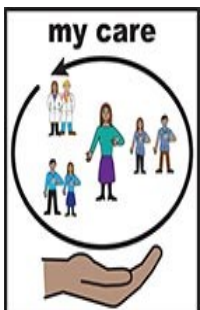




What medical problems are there in your **family's history**?  
**Mother's side - family history**                      **Fathers side - family history**



Do you need help with **seeing things clearly** or **hearing things** when at the surgery ?  
 An/or  
 When we send you letters, do they need to be in **large print** ? Yes/no



Other than the staff at the doctors surgery, what other health Professionals, Consultants, Social Workers or people from social care do you have involved with your care?



Ladies:                                      When did you last have a smear test?  
 Men/Women over 40:                      When did you last have an NHS Health Check?  
 Men/Women (All):                      What (if any) other screening have you had ?

**Summary Care Record:**

The summary care record is an electronic summary of **ONLY** your medications, allergies and any bad reactions that you have had. This information is used to treat patients safely in an emergency by allowing hospital staff who are treating an emergency patient access to the summary record. It does not contain any details of any medical conditions, test results, consultations or conversations.

If you are happy for a summary to be uploaded securely to the computer system where emergency services can access them, you need take no action as all patient records are uploaded automatically unless a patient 'opts out' by ticking below.

**To opt out. If you would NOT like your medical record to be available as a summary care record for the emergency services, please tick here.**

To see other ways that patient information is used and how we keep patient data secure, please see our website: <https://www.leighviewmedical.co.uk/about/patient-data/your-medical-record/>

**LEIGH VIEW MEDICAL PRACTICE**

**Tel: 0113 253 7628**

[www.leighviewmedical.co.uk](http://www.leighviewmedical.co.uk)

**WE ARE ACCEPTING NEW PATIENTS**

This is the new patient registration form for **16 years old** and above

One form of photo identification and One proof of address is required

**We accept the following:**

- Driving Licence
- UK Passport
- Utility bill (dated in the last 3 months)
- Council Tax
- Paper Bank Statements (dated in the last 3 months)

**Receptionist Initials:**









**Today's date:**

Please check the practice boundary covers your address BEFORE completing any forms!



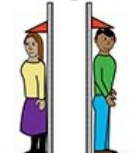






Are you from outside the UK?

How long will you be staying in the country?

<p><b>my name</b></p> 	<p>What is your <b>full name</b> and title?</p> <p>First:</p> <p>Middle:</p> <p>Last:</p>	<p><b>date of birth</b></p> 	<p>What is your <b>date of birth</b>?</p> <p>Date:</p> <p>Month:</p> <p>Year:</p>
	<p>What is your <b>full address</b> and postcode?</p>	<ul style="list-style-type: none"> <li>• Mobile phone number</li> <li>• Home phone number</li> </ul>	
<p><b>ethnicity</b></p> 	<p>What is your ethnicity? <i>e.g. White British/Chinese</i></p> <p>What is your MAIN language? <i>e.g. English / Polish</i></p>	<p><b>interpreter</b></p> 	<p><input type="checkbox"/> Do you understand English?</p> <p><input type="checkbox"/> Do you need an interpreter?</p>
<p><b>healthy and well</b></p> 	<p>What diagnosed medical conditions do you have?</p>	<p><b>allergies</b></p> 	<p>Have you ever had any allergies or sensitivities?</p> <p><b>Yes/no</b></p> <p>If yes: please list</p>
<p><b>prescription</b></p> 	<p>What medication do you take? (Please list or attach a print out.)</p> <p><i>Patients MUST request repeat prescriptions in writing ATLEAST 48 hours in advance, and allow longer if it is not already on the repeat list.</i></p> <p><b>Telephone ordering is NOT available under any circumstances.</b></p>		

16 years old and above.

<p><b>family</b></p> 	<p>Who lives with you? (their names please)</p> <p>Husband/wife/partner:</p> <p>Children (Please include ages):</p> <p>Other members of the household:</p>		
<p><b>carer</b></p> 	<p>Do you have a <b>carer</b> ? Yes/no If yes, who:</p> <p>Are you a carer for someone? Yes / no If yes, who:</p> <p>Who is your <b>emergency contact</b>: Contact number:</p>		
<p><b>height</b></p> 	<p>What is your height?</p>	<p><b>weight</b></p> 	<p>What is your weight?</p> <p>What exercise do you do &amp; how often?</p> 
<p><b>do you smoke</b></p> 	<p>Do you smoke ?</p>	<p><b>If yes:</b> How many per day?</p>	<p><b>If no:</b> <input type="checkbox"/> Never smoked Or <input type="checkbox"/> Ex-smoker?</p>
<p><b>alcohol</b></p> 	<p>1. How often do you have a drink <b>containing alcohol</b>?</p> <p>Never <input type="checkbox"/> if you tick here, your score is 0</p> <p>Monthly or less <input type="checkbox"/> if you tick here, your score is 1</p> <p>2-4 times per month <input type="checkbox"/> if you tick here, your score is 2</p> <p>2-3 times per week <input type="checkbox"/> if you tick here, your score is 3</p> <p>4+ times per week <input type="checkbox"/> if you tick here, your score is 4</p>		
<p><b>Answer 3 questions then add up the 3 scores.</b></p> <p>A total score of 5+ indicates increasing or higher risk drinking.</p> <p>If so, the can offer you information and / or support.</p> <p><b>Please ask for details.</b></p> <p>If you <b>do not</b> want to receive any alcohol support, please tick here <input type="checkbox"/></p>	<p>2. <b>How many units</b> of alcohol do you drink on a typical day when you are drinking?</p> <p>1-2 units <input type="checkbox"/> if you tick here, your score is 0</p> <p>3-4 units <input type="checkbox"/> if you tick here, your score is 1</p> <p>5-6 units <input type="checkbox"/> if you tick here, your score is 2</p> <p>7-9 units <input type="checkbox"/> if you tick here, your score is 3</p> <p>10+ units <input type="checkbox"/> if you tick here, your score is 4</p> <p>3. <b>How often</b> have you had 6 or more units (if female), or 8 or more (if male) <b>on a single occasion</b> in the last year ?</p> <p>Never <input type="checkbox"/> if you tick here, your score is 0</p> <p>Less than monthly <input type="checkbox"/> if you tick here, your score is 1</p> <p>Monthly <input type="checkbox"/> if you tick here, your score is 2</p> <p>Weekly <input type="checkbox"/> if you tick here, your score is 3</p> <p>Daily or almost daily <input type="checkbox"/> if you tick here, your score is 4</p> <p>Total score for all 3 alcohol questions added together: _____</p>		



Score:

Score:

Score: