MARCHAM ROAD HEALTH CENTRE
NEW PATIENT APPLICATION TO REGISTER (aged 13+ years)

YOU WILL NEED TO PROVIDE IDENTIFICATION TO CONFIRM YOUR NAME AND ADDRESS.

THIS SHOULD BE YOUR PASSPORT, BIRTH CERTIFICATE AND/OR MARRIAGE CERTIFICATE AND A UTILITY BILL STATING YOUR NAME AND THE ADDRESS AT WHICH YOU ARE REGISTERING.

The practice has a Patient Participation Group who work with us to represent patient views and opinion. If you would be interested in joining, please contact the Chairperson at mrfhc.ppg@nhs.net

New Patient Details

Forename(s): _____ **Surname:** _____

Gender: _____

How would you like us to refer to you (eg Mr, Mrs, Miss, Mx)? _____

D.o.B:. _____ **NHS No:** (as on Medical Card) _____

Please indicate your preferred method of contact by ticking the appropriate box next to your contact details.

Address: _____ **Tel. No's:** Home _____ ☐

_____ Work _____ ☐

_____ ☐ (post) Mobile _____ ☐

E-mail address: _____ ☐

Are you happy for us to contact you by: Text ☐ ***Email*** ☐ ***(tick the box to confirm)***

Occupation: _____ **Main spoken language**: _____

Do you need interpreting services? ☐ **If yes, which language?** _____ **BSL** ☐ **(British Sign Language)**

Next of Kin: Title: _____ **Full Name:** _____

Relationship: _____ **Telephone No:** _____

(This information may be shared with other health care professionals from time to time. If you do not wish this to happen please inform us).

Ethnicity: We are obliged to collect ethnicity information and would therefore be grateful if you would tick the appropriate box shown below.

White British		White Irish		White Other	
Black African		Black Caribbean		Indian	
Bangladeshi		Pakistani		Chinese	
Mixed Race		Other (please state)			

Medical Details

Previous Doctor (please include name and address):

1. Please list any serious illnesses, accidents, operations etc. including any pregnancies

Are you currently being treated by a hospital specialist? If yes please give details

Do you currently, or have you ever suffered from any of the following? Please tick those conditions that apply giving any details you can

Asthma	☐	Blindness/Glaucoma	☐	COPD	☐	Cancer	☐
Depression	☐	Eczema	☐	Stroke	☐	Diabetes	☐
Epilepsy	☐	Hayfever	☐	Heart Attack	☐	High Blood Pressure	☐

2. Are you currently taking any drugs (whether prescribed by your doctor or not)

Name of Medicine /Tablets	Dose/Strength	How many times per day
1.		
2.		
3.		
4.		

Please attach a current repeat prescription form from your old GP to this questionnaire if you have one.

Do you have any allergies to medication?

3. **Have you been immunised? For all patients aged up to 18 years, please give us your vaccination record (eg Child Health record or Red Book) or a printout of your immunisation list from your previous Doctor.**

4. **Do you have a major handicap or disability? If yes please give details.**

5. **Are you cared for? – if you are please give details of your carer. We will contact them to see if they are happy for their details to be included in your records.**

6. **Are you a carer? Please give details of the person you care for if they are registered as a patient at the surgery.**

7. **Have you ever served in the Armed Forces? We like to record if you are a Veteran on your medical records as it is important for us to understand more about you and your life experiences.**

Yes ☐ No ☐

8. **Do you have any issues that may affect your health e.g. employment, housing, marital, disabled family member, dependent relative etc. If yes please give details.**

9. **Do you have any family history of the following problems:-**

Heart Disease **Cancer**
Stroke **High blood pressure**
Asthma **Diabetes**

If yes, please provide family member relationship to you, problem and the age they developed this (if known).

For female patients only:-

Are you currently pregnant? Yes ☐ No ☐

If yes, please ensure you are under the care of a midwife. If you are not currently under the care of a midwife, please speak to Reception.

Have you had a cervical smear test? Yes ☐ No ☐

If yes, when was this last done? (dd/mm/yy) .....

Lifestyle Details

1. Do you smoke? Yes ☐ No ☐ If yes, since when……

How many per day? Cigarettes _____ Cigars ____ Pipe Tobacco _____ (oz) Electronic cigarette ☐

If you have smoked in the past when did you give up? _____

If you currently smoke and want support to give up, please go to https://www.stopforlifeoxon.org/ or https://www.nhs.uk/live-well/quit-smoking/

2. Do you drink alcohol? Yes ☐ No ☐

If yes how many units do you have each week?

One unit = 1 single measure of spirits, ½ pint of beer or 125ml glass of wine

Beer/Lager/Cider _____ Wine _____ Spirits _____

Government recommended weekly alcohol limit is 14 units per week for men and women.

If you exceed the government recommended intake, please go to www.drinkaware.gov.uk for advice and Guidance, or discuss with a GP.

3. What is your current:

Weight _____ st _____ lb **Height** _____ft _____"

_____kilos _____ metres

4. What do you consider to be your current state of health?

For online services, please register with the NHS App:

www.nhs.uk/nhs-app

The NHS App is available on iOS and Android

Download on the App Store GET IT ON Google Play

If you do not wish to share your medical information with another NHS healthcare setting (i.e. Emergency Department or Minor Injuries Unit) you should opt out of the Summary Care Record schemes. Please print, complete and return the (National) Summary Care Record and Oxfordshire Care Summary consent form.