Dr A Bisarya & Partner
Sandy Lane Health Centre

Please use BLOCK CAPITALS and answer all questions.
The details provided will be included in your medial record.

`OFFICE USE ONLY – Date Initials of Authorising Dr		
Pre Reg	Health info Entered?	Pt No
Full Reg		

Personal Details

Mr Mrs Miss Ms
Other …….
Male Female
Surname …….
Previous Surname…….
First Names ……
Date of Birth ……
NHS Number (if known) …….
Town & Country of birth……

Current Address …….
…….
…….
Post code …….
Home Telephone …….
Mobile Telephone…….

If you are from abroad the date you came to the UK…….

Previous GP Details

Have you ever been registered with a GP in the UK? Yes No
Name & Address of Previous GP (compulsory) ……
Your previous address in UK (compulsory) ……Postcode……

Other Members of your Household

Names	D.O. B	and the name of their present GP
……		……
……		……
……		……
……		……

If you are from Abroad Yes/No

Country/Nationality…….
Date you first came to UK ……
Your first address in UK ……
If previously resident in UK
Date of leaving ……

Have you ever been registered or Attended a GP in the UK?
Yes No

If Yes name & address of GP…….
……
……

Important information please read the attached letter regarding your health record before signing below.

Consent to join A Bisarya's Signature of patient Signature on behalf of patient	…… Date…….
Name of signatory Relationship to Patient	…….. ……..

(all persons over the age of 16 must sign their own form)

Your ethnic group

Please choose one of the sections below & tick your group

(Please tick one only) The ethnic group descriptions are a national standard taken from the 2001 census	**White** White British White Irish White Other	**Mixed** White & Black Caribbean White & Black African White & Asian Other …….
Asian/Asian British Indian Pakistani Bangladeshi Other ……	**Black/Black British** Black Caribbean Black African Somali Other ……	**Chinese or Other** Chinese Middle Eastern Any other …….

Main spoken Language	Other Languages	Do you have any problem understanding & speaking English? Yes No

Health & Lifestyle

Do you take regular medication? Yes No

If Yes, please list all medication ……..
……
……..

Have you ever been admitted to hospital?	Yes	No
Have you ever had an operation?	Yes	No
Do you have any long-term illness or Health problem?	Yes	No
Do you have or ever had any mental health problems including depression?	Yes	No
Do you have any disabilities?	Yes	No

Are you a military veteran? Yes No

Army Navy Air force

Do you live alone Yes No

Are you single / married / divorced / separated / widowed? (please circle)

Are you a registered Carer? Yes No
(person who looks after someone who is ill, frail, disabled or mentally ill)

Are you cared for Yes No

Do you smoke?	Never smoked	I smoke	I smoke a pipe
	Ex - smoker	……. Cigarettes a day	
Do you drink Alcohol?	Yes No	Number of Units per week ……	
	½ pint of beer / lager, 1 single measure of spirit, 1 glass wine = 1 unit		

Allergies please list - …… Date of last Tetanus injection (if known) …….
……

Fitness – which best describes your level of Fitness.
No exercise Infrequent exercise Once a week More than twice a week

Diet – which best describes your diet
Normal Healthy Reducing Diabetic Vegetarian Other …….

Family History Do or did any of your immediate family i.e. parents / grandparents / brothers / sisters / children suffer from any of the following:

	Which family member	Diagnosed at age
Stroke		
High Blood Pressure		
Cancer		
Diabetes		
Heart Attack		
Asthma		

Major Illnesses Please list:

NHS Organ Donor registration –voluntary

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death.
Please circle as appropriate
Kidneys Heart Liver Corneas
Lungs Pancreas Any part of my body

Signature confirming consent to organ donation

…….

Date ……

For more information, please see the organ donation leaflet

NHS Blood Donor registration – voluntary

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.
Tick here if you have given blood in the last 3 years.

Signature confirming consent to inclusion on the NHS Blood Donor Register

……

Date …….

For more information, please see the blood donor leaflet

This form should be retained by the practice for two years as per LASCA guidelines

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Name .....

Date of birth.....

Please complete the following questions by ticking the box of the answer that applies to you

Your results will be evaluated, and we may contact you for further information or to offer you extra support where appropriate.

1. **How often do you have eight or more drinks on one occasion?**

Never	Less Than Monthly	Monthly	Weekly	Daily or Almost Daily

2.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

3. **How often during the last year have you failed to do what was normally expected of you because of your drinking?**

Never	Less Than Monthly	Monthly	Weekly	Daily or Almost Daily

4.Has a relative or friend, a doctor or other health worker been concerned about your drinking or suggested you cut down?

Never	Less Than Monthly	Monthly	Weekly	Daily or Almost Daily

I confirm that the above information is accurate and a true reflection of my alcohol intake

Signed.....Date.....

(practice use only)

NO ACTION	BRIEF INTERVENTION	REFERRED FOR FURTHER CARE	Scanned into records