Please bring along with you proof of ID
ie. passport, driving licence, birth certificate, utility bill, bus pass.

The Mayflower Medical Practice

www.mayflowermedicalpractice.nhs.uk

Please complete this questionnaire as fully as possible and pass back to Reception.

The information that you provide will help us assess your current health needs. This information is required to register you at the Practice. You will also be required to arrange an appointment to see one of our Healthcare Assistants for a New Patient Check. This involves going through this questionnaire and answering a few more questions about your health.

PERSONAL INFORMATION

Title: Mr / Mrs / Miss / Ms / Rev / Prof / Dr

Surname:	**Fornames:**	**Middle Name:**
Date of Birth:	**Sex:**	**NHS No:**

Address:

Postcode:

Telephone: Home No: Mobile No:

The Practice offers a text messaging service to patients, if you would like to receive text messages from us please tick this box. Please ensure you have given us your mobile number, if you change your mobile number please keep us updated. ☐

Next of Kin:

Children/Students only:
Which school do you attend:

First Language:

What is your ethnic group? Please circle:

Asian	Bangladeshi	Black African	Black Caribbean	Black Other
Chinese	Indian	Pakistani	White British	White other

If other please specify .....

	Yes	**No**
Are you a carer?		
Do you have a carer?		

PERSONAL MEDICAL HISTORY

Do you suffer from any of the following:

	Yes	**No**
Asthma, bronchitis, COPD, frequent chest infections		
Depression/mental illness		
High cholesterol/fat in the blood		
High blood pressure		
Heart problems		
Diabetes		
Stroke		
Epilepsy		

	Yes	No
Do you have any disabilities? (eg deafness, loss of sight, loss of limbs)		
Please describe:		
	Yes	**No**
Diet: Do you eat a varied diet?		
Are you a vegetarian, vegan ..? please describe:		
	Yes	**No**
Exercise: Do you exercise?		
How many hours per week?		
	Yes	**No**
Have you had any operations: (eg tonsillectomy, appendicectomy, hip replacement etc..)		
Please describe:		
	Yes	**No**
Do you have any allergies?		
If yes, please specify:		

HEALTH/LIFESTYLE INFORMATION

Height ..... **Weight** .....

Please complete the section below if you are aged 16 years and above.

Questions	0	1	2	3	4
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 units 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 units on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

Would you like to discuss your alcohol intake if we feel that your current intake puts you at risk? Yes / No

If so, how would you like to be contacted: Letter ☐ Telephone ☐

	Yes	No
Do you smoke?		
If yes how many per day		
	Yes	**No**
If no, have you ever smoked?		
When did you stop		

YOUR MEDICATIONS

Medication	Dose	Frequency	Why do you take this drug?
Please include creams, appliances, seasonal medication and over the counter medicines.			

IMMUNISATIONS

	Yes	No
Are you up to date with your Tetanus and Polio Immunisations? If you are not sure tick No		
	Yes	**No**
Do you have an annual flu injection?		

FAMILY HISTORY

Do any close relatives (mother/father/brother/sister) have heart disease, stroke, diabetes, cancer or any other condition? Please specify the condition and relationship and age if known:

Condition	Relationship	Age

NEW MUMS

If you have recently had a baby we would like to know your Hepatitis B status – please circle

Negative / Positive

By registering at the Practice you will have a Computerised Summary Care Record created. If you do not wish to have a Summary Care Record, you must inform the Practice so that we can mark your records to say you have declined this.