

NEW PATIENT QUESTIONNAIRE HIGH FIELD SURGERY

Dear patient, to register with the practice please complete (GMS1) attached, and this New Patient Registration Form. Please complete all sections of the forms by writing clearly or by ticking the relevant boxes. Separate forms should be completed for others in your household who wish to register. Also please make an appointment with the Healthcare Assistant for a new patient health check. The Healthcare Assistant will be pleased to help you fill in these forms. If you do not want to have an appointment with the Healthcare Assistant just yet please hand the completed forms to the receptionist who will also provide help if required.

1) Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	2) Title <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Other	7) Ethnicity <i>White</i> <input type="checkbox"/> White British <input type="checkbox"/> White Irish <input type="checkbox"/> White other <i>Black/Black British</i> <input type="checkbox"/> Black Caribbean <input type="checkbox"/> Black African <input type="checkbox"/> Black other <i>Asian/Asian British</i> <input type="checkbox"/> Asian Indian <input type="checkbox"/> Asian Pakistani <input type="checkbox"/> Asian Bangladeshi <input type="checkbox"/> Asian other <i>Chinese/Chinese British</i> <input type="checkbox"/> Chinese	<i>Mixed</i> <input type="checkbox"/> White & Black Caribbean <input type="checkbox"/> White & Black African <input type="checkbox"/> White & Asian <input type="checkbox"/> Other Mixed <i>Other</i> <input type="checkbox"/> Other Ethnic Group <i>Decline</i> <input type="checkbox"/> Decline to say What is your first language?
3) Family Name (surname)			
4) First Name			
5) Date of Birth <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Day Month Year	NHS Number: (if known)		
8) House Number & Street		10) Home Telephone No:	
		11) Mobile No:	
9) Postcode	12) Email		

113) If you have any significant health problems please provide details of who we may contact in an emergency:

Name: _____ Telephone Number: _____
Relationship to you: _____

Any significant health problems – if yes please give year of diagnosis:-

- Atrial Fibrillation
- Absent spleen (Asplenic)
- Asthma
- COPD (e.g. emphysema or chronic bronchitis)
- Coronary heart disease (e.g. heart failure, myocardial infarction and angina)
- Current kidney disorders
- Depression
- Diabetes
- Epilepsy
- High blood pressure
- Hypothyroidism
- Stroke/CVA/TIA
- Any other significant problem (Please detail)

MEDICINES – If you take medication regularly (including contraception, tablets, cream and inhalers) please give the right hand side of your repeat prescription to reception, ticking any items you require. Please bring your medication with you when you attend for an appointment with the doctor.

ANY ALLERGIES OR REACTIONS? (e.g. to: eggs, medicines, vaccinations, medical dressings or foodstuffs):

Please provide as much medical history as you can below

Smoking status

- I have never smoked
 I am a current smoker, and smoke
 I am an ex-smoker and used to smoke:
- less than 1 per day
 less than 1 per day
- 1 to 9 per day
 1 to 9 per day
- 10 to 19 per day
 10 to 19 per day
- 20 to 39 per day
 20 to 39 per day
- More than 40 per day
 More than 40 per day
- Date stopped:

FOR ADVICE ON STOPPING SMOKING CONTACT LEEDS SMOKING SERVICES ON 0113 2033 446

Height		Is this measurement in <input type="checkbox"/> metres <input type="checkbox"/> feet and inches
Weight		Is this measurement in <input type="checkbox"/> kilograms <input type="checkbox"/> stones and pounds
Blood Pressure		This measurement can be taken by yourself, your pharmacist or you can book in with the Healthcare Assistant at the surgery. (Please bring this form with you)

Any medical history in blood relatives under 65 years of age

- Heart disease
 Stroke
 Diabetes
 Other – please specify

Fast Alcohol Screening Test (FAST)

Question	Scoring system					Your score
	0	1	2	3	3	
How often do you have 8 (men)/ 6 (women) or more drinks on one occasion						
Only answer the following questions if your answer above is monthly of less						
How often in the last year have you not been able to remember what happened when drinking the night before						
How often in the last year have you failed to do what was expected of you because of drinking						
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down						

Scoring: A total of 3+ indicates hazardous or harmful drinking

FEMALES ONLY

Girls born between 1.9.90 and 31.8.91 Have you had HPV vaccinations 1st [] 2nd [] 3rd []

Are you pregnant? No Yes - number of weeks ()

Further details about the practices and the services which we provide can be found in our practice leaflet or on our website www.highfieldsurgery.com. We welcome you to High Field Surgery.