PLEASE ENSURE PROOF OF ADDRESS AND IDENTITY IS SHOWN ON COMPLETION

Upper Gordon Road Surgery

RECEPTIONIST'S INITIALS:

U.K RESIDENTS REGISTRATION FORM

Date of entry into UK

PLEASE COMPLETE IN BLOCK CAPITALS
LEGIBLY & IN FULL OTHERWISE
WE ARE UNABLE TO PROCESS YOUR REGISTRATION

EMIS No:

NHS NUMBER:

MR ☐ MRS ☐ MISS ☐ MS ☐

Date Of Birth

First name
Middle name
Surname
Previous surname

Home address:

Home phone
Mobile phone
Email address
Preferred communication Mobile ☐ Email ☐ both ☐

Previous home address

Postcode

Town of birth

Postcode

Signature:
Date:

THIS INFORMATION IS REQUIRED TO ALLOW US TO TRACE YOUR MEDICAL RECORDS – PLEASE FILL IN ALL BOXES

NAME OF PREVIOUS GP: (e.g. Dr Kershaw)
.....
.....

NAME OF PREVIOUS G.P PRACTICE:
.....
.....

ADDRESS OF PREVIOUS GP PRACTICE:
.....
.....
.....

IF YOU ARE RETURNING FROM THE BRITTISH ARMED FORCES :

ADDRESS BEFORE ENLISTING
.....
.....

SERVICE NUMBER
.....
.....

ENLISTMENT DATE
.....
.....

NEXT OF KIN/ EMERGENCY CONTACT DETAILS (NOK):

Name of NOK		
Relationship		
Home phone		
Mobile phone		
Do you care for someone?	Yes ☐	No ☐

IN THE EVENT OF AN EMERGENCY CAN WE CONTACT THIS PERSON?

☐ YES ☐ NO

NEW PATIENT HEALTH QUESTIONNAIRE

PLEASE COMPLETE THIS QUESTIONNAIRE ALONG WITH ANY OTHER INFORMATION YOU FEEL WE SHOULD KNOW

ALL INFORMATION IS TREATED IN STRICT CONFIDENTILITY

HOW TALL ARE YOU? _____ CM HOW MUCH DO YOU WEIGH? _____ KG

WE PROVIDE ACCESS FOR SELF MONITORING YOUR BLOOD PRESSURE IN 'POD' ROOM LOCATED ON THE 1ST FLOOR. PLEASE BRING YOUR READING TO RECEPTION AFTERWARDS TO RECORD THIS INFORMATION.

SMOKING HISTORY CURRENT SMOKER ☐ **EX SMOKER** ☐ **NEVER SMOKED** ☐

PLEASE CIRCLE – CIGARETTES - TOBACCO - CIGARS – PIPE HOW MANY A DAY ☐

EX SMOKER – WHEN DID YOU STOP SMOKING (DD, MM, YYYY)? _____

WE PRIDE OURSELVES ON HELPING, SUPPORTING AND ACTIVELY ENCOURAGING SMOKERS TO 'QUIT' AND CAN PROVIDE ONE TO ONE IN HOUSE SUPPORT AND THERAPY. WOULD YOU LIKE ONE OF OUR SMOKING CESSATION ADVISERS TO CONTACT YOU? YES ☐ **NO** ☐

ARE YOU ALLERGIC TO ANY MEDICINES – E.G PENICILLIN OR ASPIRIN?

PLEASE LIST ANY SERIOUS ILLNESS OR OPERATION YOU HAVE HAD, AND THEY YEAR IT OCCURED

PLEASE BRING IN A COPY OF YOUR REPEAT PRESCRIPTION TO YOUR FIRST GP APPOINTMENT

DATE, LOCATION AND RESULT OF LAST CERVICAL SMEAR TEST:

FAMILY MEDICAL HISTORY:

Father	Mother	Brother	Sister	Other

NHS ORGAN DONOR REGISTRATION

I DO NOT WANT TO DONATE MY ORGANS ☐

Any of my organs and tissue ☐	Heart ☐	Liver ☐	Corneas ☐	Lungs ☐
Pancreas ☐	Any part of my body ☐	Signature_____ Date _____		

NHS BLOOD DONOR REGISTRATION

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 THREE YEARS. ☐ **YES**

SIGNATURE CONFIRMING CONSENT TO INCLUSION ON THE NHS BLOOD DONOR REGISTER

SIGNATURE _____ DATE_____

NEW PATIENT HEALTH QUESTIONAIRE CONTINUED

PLEASE HELP US PLAN FOR THE FUTURE HEALTHCARE OF OUR POPULATION BY PROVIDING INFORMATION ON YOUR ETHNICITY. PLEASE CIRCLE ONE ONLY

WHITE	BRITISH
	IRISH
	ANY OTHER WHITE BACKGROUND
MIXED	WHITE AND BLACK CARIBBEAN
	WHITE AND BLACK AFRICAN
	WHITE AND ASIAN
	ANY OTHER MIXED BACKGROUND
ASIAN OR ASIAN BRITISH	BANGLADESHI
	INDIAN
	PAKISTANI
	ANY OTHER ASIAN BACKGROUND
BLACK OR BLACK BRITISH	CARRIBBEAN
	AFRICAN
	ANY OTHER BLACK BACKGROUND
OTHER ETHNIC GROUPS	CHINESE
	ANY OTHER ETHNIC GROUP
DECLINE TO PROVIDE ETHNIC GROUP	

MAIN LANGUAGE SPOKEN ? ……..

ANY OTHER APPROPRIATE INFORMATION YOU FEEL WOULD BE HELPFUL TO YOUR NEW GP

Regular Exercise

Daily	Weekly	Monthly	Never Exercise	Other

Before handing this form back please check:

☐ Form is completed in FULL and is LEGIBLE

☐ Proof of address and Photo ID

☐ Form has been signed (on page 1)

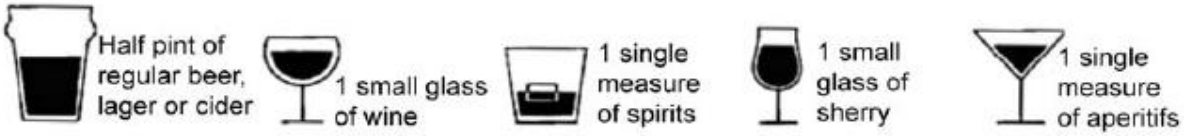
☐ Please tick if you require your prescriptions to be sent electronically to any local Pharmacies (please indicate) _____

It would be helpful if you are able to wait 48 hours (2 working days) before making an appointment.

Please bring our repeat medication list to your first GP appointment, plus any other relevant information.

ALCOHOL INTAKE

PLEASE ANSWER THE FIRST FOUR QUESTIONS



EACH OF THE ABOVE IS ONE UNIT OF ALCOHOL

EACH OF THESE IS MORE THAN ONE UNIT OF ALCOHOL

How many units of alcohol do you have a week? ☐

PLEASE CIRCLE THEN ADD UP YOUR SCORE BELOW

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

YOU ARE VERY WELCOME TO MAKE AN APPOINTMENT WITH THE NURSE OR DOCTOR TO DISCUSS YOUR ALCOHOL COSUMPTION AT ANY STAGE; IN TURN WE MAY CONTACT YOU IF THERE ARE ANY CONCERNS.

ADD UP SCORES IN 3 BOXES ABOVE & PUT TOTAL IN HERE

TOTAL AUDIT C ☐

IF YOU HAVE SCORED 5+ IT MAY INDICATE HAZARDOUS OR HARMFUL DRINKING. PLEASE THEN COMPLETE THE MORE DETAILED AUDIT OVERLEAF

IF YOU HAVE SCORED LESS THAN 5 THERE IS NO NEED TO ANSWER THE QUESTIONS OVERLEAF AND YOU MAY HAND YOUR FORM BACK TO A RECEPTION DESK.

ONLY COMPLETE IF SCORE ON PREVIOUS PAGE IS 5 OR MORE

Remaining alcohol questions

Questions	Scoring system					Your score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

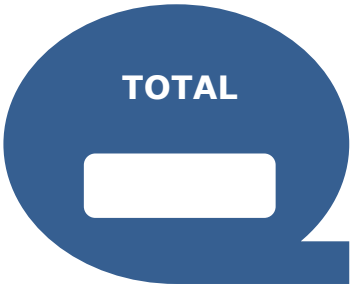
ABOVE TOTAL ☐

☐

Total Audit C (FROM PREVIOUS PAGE) ☐

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 higher risk, 20+ possible dependence

TOTAL Score equals
AUDIT C Score (Previous page)+
Score Above



OFFICE USE ONLY:

IF SCORE OVER 15 PLEASE PROVIDE BRIEF INTERVENTION LETTER.