Royal Crescent and Preston Road Practice

New Patient Registration

This form must be filled out by all Patients registering with our Practice.
Please return this form with your GMS1 form or Medical Card to Reception,
so we can complete your registration.

It may be some time before we receive your medical records, so the following information will be helpful to us in assessing your health care needs.

Personal Information

Title: _____ Forename: _____ Surname: _____

Date of Birth: _____ Age: _____

Address: _____

_____

Postcode: _____

Telephone Numbers

Home: _____ Work: _____

Mobile: _____

Occupation: (if retired please state previous occupation) _____

Height _____ Weight _____

Smoking Status

	Please tick		
Never Smoked			
Ex Smoker		When did you give up?	
Current Smoker		How many do you smoke per day?	
In the interest of your health and wellbeing, the Doctor advises that you give up smoking.			
Would you like a referral to Dorset Smokestop? They offer free support and can provide patches, gum etc on prescription.			YES/NO

Please turn over

Do you have any Significant Medical Problems (e.g. Asthma, Diabetes) **YES** ☐ **NO** ☐

Are you prescribed any regular medication/having regular injections? **YES** ☐ **NO** ☐

Newly registered patients taking regularly prescribed medication or having regular injections will need to see the Nurse Practitioner or Doctor before you are due your first prescription or injection

Anything else you would like the Doctor to know? (i.e. Family History of illnesses)

_____

_____

_____

_____

_____

Next of Kin Details

Name: _____

Address & Tel No: _____

_____

Carer Details

Are you a carer, do you care for someone?

Name of person I care for: _____

Contact details of person I care for: _____

_____

Date form completed: _____

Office use only:

Welcome pack given out to every patient over the age of 15		Information coded on computer	
If on current medication or has regular injections make an appointment for NP or GP		Alcohol protocol followed	
If over 45 – make an appointment for HCA for BP check			
Smoking advice information given to patient if needed			

Alcohol Intake

Please circle the relevant answer

Questions	Scoring system					Your Score
	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 standard alcoholic drinks 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 standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
				Total Score		

If you have scored 5 or more on the above questions, please could you now complete the remaining questions

Questions	Scoring system					Your Score
	0	1	2	3	4	
How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or someone 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 /friend /doctor/ health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	
				Total Score		

Total Score for both sets of Questions

Please turn over

What is your ethnic group? Choose ONE section from A to E, then tick the appropriate box on the right to indicate you ethnic group

Ethnic Group	Tick here
A: White	
• British	
• Irish	
• Any other White background (please state)	
B: Mixed	
• White and Black Caribbean	
• White and Black African	
• White and Asian	
• Any other mixed background (please state)	
C: Asian or Asian British	
• Indian	
• Pakistani	
• Bangladeshi	
• Any other Asian background (please state)	
D: Black or Black British	
• Caribbean	
• African	
• Any other Black background (please state)	
E: Chinese or other ethnic group	
• Chinese	
• Any other (please state)	
Not stated / Declined: Declined: patient chooses not to supply this information	

What is your main spoken language (please tick)

Akan (Ashanti)		Hakka		Serbian	
Albanian		Hausa		Shona	
Amharic		Hebrew		Sinhala	
Arabic		Hindi		Somali	
Bengali		Igbo (Ibo)		Spanish	
Brawa		Italian		Swahili	
British Sign Language		Japanese		Swedish	
Cantonese		Korean		Sylheti	
Croatian		Kurdish		Tagalog (Filipino)	
Czech		Kutchi		Tamil	
Dutch		Lingala		Thai	
English		Lithuanian		Tigrinya	
Ethiopian		Luganda		Turkish	
Farsi (Persian)		Makaton Sign Language		Ukrainian	
Finnish		Malayalam		Urdu	
Flemish		Mandarin		Vietnamese	
French		Norwegian		Welsh	
French Creole		Pashto (Pushtoo)		Yoruba	
Gaelic		Patois		Other (Please write in line below	
German		Polish			
Greek		Portuguese		Patient Refused	
Gujerati		Punjabi			
		Russian			