The Elms Medical Centre
NEW PATIENT REGISTRATION FORM

Please complete this confidential questionnaire in BLOCK CAPITALS and tick the boxes as appropriate. Please bring either a passport or photograph driving licence to confirm your identity, and a utilities bill showing your current address

IF YOU HAVE A CHRONIC ILLNESS AND/OR YOU ARE ON REGULAR REPEAT MEDICATION, YOU WILL BE REQUIRED TO HAVE A NEW PATIENT HEALTH CHECK.

Surname		Telephone Number (Home)
First Names		Telephone Number (Mobile)
Mr/Mrs/Miss/Ms/Other		Telephone Number (Work)
DoB	Occupation	Next of kin
Address and Postcode		Do you consent to the surgery sending text messages to your mobile number to remind you of appointments? Yes ☐ No ☐

Please tick any relevant groups you may belong to:

Military Veteran ☐ If you have ever served in armed forces	**Student** ☐	
Asylum Seeker ☐ **Evidence required if ticked**	**Refugee** ☐	**Traveller/Gypsy** ☐
Homeless ☐	**Living in a Hostel** ☐	**Living in B&B accomodation** ☐

Ethnic Origin:

White	White British ☐ White Irish ☐ Other white ☐ Please state……..		
Mixed	White and Black Caribbean ☐ White and Black African ☐ White and Asian ☐ Other mixed Please state ……		
Asian	Indian ☐ Pakistani ☐ Bangladeshi ☐ Other Asian Please state ……..		
Black / Black British	African ☐ Caribbean ☐ Other Black background Please state ……		
Other ethnic groups	Chinese ☐ Other ethnic group Please state …… Patient chose not to indicate ☐		
Main/1st language Spoken/Read	Please state ……	Do you need an interpreter?	Yes/No

Females Only:

A full confidential contraceptive service (including condoms and emergency contraception) is available from the practice.		
If you require this service now please tick ☐	Have you ever had a cervical smear?	Yes ☐ When …… No ☐
Have you ever been pregnant? Yes/No	Pregnancy details if yes	

Specific Needs: **Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action**:					
Please State any Sensory Impairment you have (i.e. Speech, Hearing, Sight):					
Have you a physical or mental disability? If yes, please give details					
Are you a carer?	Yes/No	If yes, are they a patient with this surgery?	Yes/ No	If yes, who do you care for?	
Have you got a carer?	Yes/No	If yes, who is your carer?		What are their contact details?	

Smoking, Alcohol Consumption, Diet and Exercise			
Are you currently a smoker?	Yes/No	Have you ever been a smoker?	Yes/No
If currently a smoker, how many cigarettes per day?		Would you like to be referred to for support to help you stop smoking?	Yes/No
Do you drink alcohol?	Yes/No	If yes, complete table on page 3	
What is your height? What is your weight?		Blood pressure reading Urine sample given	 Yes/No
How good is your diet?	Very good ☐ Good ☐ Average ☐ Poor ☐ Vegetarian ☐	Please complete Exercise questionnaire on page 4	

Your Medical Background:	
Do you have any medical problems at present?	
Do you have any past SIGNIFICANT medical problems?	
Are you on any regular medication? If so, what?	
Do you have any allergies? If so, what?	
Do you have any family history (parents/siblings/grandparents)of: Heart attack, Stroke, Cancer, Diabetes, Asthma, High Blood Pressure or any other significant medical conditions. Yes ☐ No ☐ If **YES**, please give detail opposite.	Heart attack age/relation …… Stroke/Thrombosis age/relation …… Cancer age/relation …… Diabetes age/relation …… Asthma age/relation …… High BP age/relation …… Other age/relation ……
When did you have your last tetanus booster? …… Are you planning foreign travel that you may need immunisation for? Yes ☐ No ☐	

UNIT GUIDE

1 unit is typically:

Half-pint of regular beer, lager or cider; 1 small glass of low ABV wine (9%); 1 single measure of spirits (25ml)

The following drinks have more than one unit:

A pint of regular beer, lager or cider, a pint of strong /premium beer, lager or cider, 440ml regular can cider/lager, 440ml "super" lager, 250ml glass of wine (12%)

The following questions are validated as screening tools for alcohol use

AUDIT- C 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	
					TOTAL :	

A score of **less than 5** indicates *lower risk drinking* (see overleaf)

Scores of 5+ requires the following 7 questions to be completed:

AUDIT Questions (after completing 3 AUDIT-C questions above)	**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	
					TOTAL	

Physical Activity

1. Please tell us the type and amount of physical activity involved in your work.

		Please mark one box only
a	I am not in employment (e.g. retired, retired for health reasons, unemployed, full-time carer etc.)	
b	I spend most of my time at work sitting (such as in an office)	
c	I spend most of my time at work standing or walking. However, my work does not require much intense physical effort (e.g. shop assistant, hairdresser, security guard, child-minder, etc.)	
d	My work involves definite physical effort including handling of heavy objects and use of tools (e.g. plumber, electrician, carpenter, cleaner, hospital nurse, gardener, postal delivery workers etc.)	
e	My work involves vigorous physical activity including handling of very heavy objects (e.g. scaffolder, construction worker, refuse collector, etc.)	

2. During the *last week*, how many hours did you spend on each of the following activities?
Please answer whether you are in employment or not.

	Please mark one box for each row	None	Some but less than 1 hour	1 hour but less than 3 hours	3 hours or more
a	Physical exercise such as swimming, jogging, aerobics, football, tennis, gym workout etc.				
b	Cycling, including cycling to work and during leisure time				
c	Walking, including walking to work, shopping, for pleasure etc.				
d	Housework/Childcare				
e	Gardening/DIY				

3. How would you describe your usual walking pace? Please mark one box only.

Slow pace (i.e. less than 3 mph)		Steady average pace	
Brisk pace		Fast pace (i.e. over 4mph)	

Patient Participation Group The Practice is committed to improving the services we provide to our patients. To do this, it is vital that we hear from people about their experiences, views, and ideas for making services better. If you are interested in getting involved, please tick the box below and we will send the necessary information to you.	
Are you interested in becoming involved in the **Practice Patient Participation Group**	Yes ☐ No ☐
Patient Signature	

Thank you for completing this form

For more information about the practice, please refer to our website: www.theelmsmedicalcentre.nhs.uk/