New Patient Registration Questionnaire (BLOCK CAPITALS PLEASE)

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| --- |
| Name: |
| Address: |
| Tel No: (Home) |
| Tel No: (Mobile) |
| Which number above is your preferred contact number? Home/Mobile\* (\*delete as appropriate) |
| Date of Birth: |
| Date of Registration |
| Email address: |

Please answer the following questions:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do you smoke? | | Yes | | No |
| If yes, how many a day | |  | | |
| If no, have you ever smoked | | Yes | | No |
| If yes, how many a day | |  | | |
| Do you know your height? If so, please state | |  | |  |
| Do you know your weight? If so, please state | |  | |  |
| Are you on any medication? | | Yes | | No |
| If yes, please give details: | | | | |
| Do you have a recent blood pressure reading? If so, please state |  | | | |
| Do you have a coil or implant fitted? | Yes | | No | |
| If yes, when did you have it fitted? | | | | |

|  |  |  |
| --- | --- | --- |
| Do you have any allergies? | Yes | No |
| If yes please give details: | | |
| Are you a Carer? | Yes | No |
| Do you have a carer? | Yes | No |
| If yes give name and address and telephone number: | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Next of Kin/Emergency Contact | | | |
| Name |  | | |
| Address |  | | |
| Telephone Number |  | | |
| Relationship |  | | |
| Do you consent to your next of kin having access to your record? | | Yes (if so, please sign below) | No |

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Do you have a preference to which Doctor you are registered with at this practice? If not, your registered Doctor will be Dr Featherstone, but you can still book an appointment to see any Doctor of your choice. | Yes | No |
| If yes, please give details: | | |

|  |  |
| --- | --- |
| Please tick to indicate your ethnic group | |
| White |  |
| Black Caribbean |  |
| Black African |  |
| Black, other, non-mixed origin |  |
| Black – other, mixed |  |
| Indian |  |
| Pakistani |  |
| Bangladeshi |  |
| Chinese |  |
| Vietnamese |  |
| Other Black ethnic group |  |
| Other Asian ethnic group |  |
| Other ethnic group |  |

|  |  |
| --- | --- |
| Do you need any form of communication support? Please tick if you require any of the following when we communicate with you, or let us know if you have any other communication needs which are not listed here | |
| Large Print |  |
| Sign Language |  |
| Braille |  |
| Email |  |
| Other communication support |  |

Text Messaging

If you are happy to receive text messages to remind you about appointments etc. please sign below to give your consent for this.

I give my consent to Stockwell Road Surgery to send me reminders via text message on the above number.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you would like to order repeat prescriptions and book appointments online, please download the NHS app.