New Patient Registration Questionnaire

| Name: |
| --- |
| Address: |
| Tel No: |
| 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: | | |
| Have you had any of the following? | | |
| Heart Disease | Yes | No |
| High Blood Pressure | Yes | No |
| Diabetes | Yes | No |
| Asthma/Lung Problems | Yes | No |
| Epilepsy | Yes | No |
| Thyroid Problems | Yes | No |
| Stroke | Yes | No |
| Mental Health Problems | Yes | No |
| Cancer | Yes | No |

| Name: | | |
| --- | --- | --- |
| 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 have a preference to which Doctor you are registered with at this practice? If not your registered Doctor will be Dr McCready 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 |  |

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.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this Mobile Number your preferred contact telephone number? Yes/No

If not please provide this number: \_\_\_\_\_\_\_\_\_\_\_\_

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

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