BRIDPORT medical CENTRE

NEW PATIENT REGISTRATION FORM

UNDER 16

Please complete in block capitals and circle where appropriate.

Please ensure you bring ID with you when returning this form.

PATIENT DETAILS

Mr Miss Other		Surname:	
Date of Birth	/ /	First Names:	
NHS No:		Previous name/s:	
Male/Female:		Town and Country of Birth:	
Home Address:			
Postcode:		Home Telephone Number:	
Email Address:			
School currently attended:			

ETHNICITY

Please circle your ethnicity below:			
British	Irish	Other White Background	White and Black Caribbean
White and Black African	White and Asian	Any other Mixed Background	Indian
Pakistani	Bangladeshi	Other Asian Background	Caribbean
African	Any other Black Background	Chinese	Any Other Ethnic Group
Not Stated	Declined	First Spoken Language:	

NEXT OF KIN DETAILS

Name:			
Relationship to you:		Contact Number:	
Address:			

Please help us trace your previous medical records by providing the following information:

Your Previous Address in the UK:	
Name of Previous Doctor while at this address:	
Address and telephone number of Previous Doctor:	
If applicable, date you first came to live in the UK:	

HOUSEHOLD MEMBERS (including non-family members)

Surname	Forename	Date of Birth	Relationship to Patient

YOUR HEALTH

Health Problems: Please tick if you have a history of any of the following health problems:			
Cancer		Coronary Heart Disease, Heart Failure or Atrial Fibrillation	
Dementia or Alzheimers		Depression or Mental Health Problems	
Hypertension (High Blood Pressure)		Kidney Disease	
Respiratory Difficulties (Asthma or COPD)		Stroke or Transient Ischemic Attacks	

Diabetes		Learning Difficulties	
Epilepsy		Thyroid Disease	

If you have any other history, important illnesses or disabilities not mentioned above please give details here (include special diet requirements):

ALLERGIES: Please list any allergies you have:	

MEDICATION: If you are currently taking any repeat medication, please attach a copy of your repeat prescription to the form when you hand it in. You will need to book a telephone appointment with a GP to discuss your medication. Please make sure you have enough medication to last you until your appointment with the GP.

NOMINATED PHARMACY: With the use of the Electronic Prescription Service (EPS) repeat prescriptions can be sent direct to a pharmacy of your choice through IT systems removing the need for you to collect a paper prescription from the Practice to take to the pharmacy. If you'd like to take advantage of this system please circle a pharmacy below. **Please see leaflet for more information.**

Lloyds	Well	Boots

FAMILY HISTORY

Please tick any medical condition which affects or has affected your parents, brother(s) or sister(s)

Diabetes		Heart Attack/Disease	
Asthma		High Blood Pressure	

Stroke		Breast Cancer	
Bowel Cancer		Thyroid Disorder	
Any other important family illness:			

IMMUNISATIONS

Please tick immunisations that you have had? (Tick all that apply)			
Diphtheria		Whooping Cough	
German Measles		Tetanus	
Polio		MMR	
Pre-School Booster		Triple Vaccine (Diphtheria, Tetanus and Pertussis)	

FOR FEMALES AGED 15-65 – if you use any form of contraception please circle below

Coil	Depot Injection	Implant	Oral Pill	Patches
Other (please detail):				
When was your last contraceptive check-up/review with a GP or Nurse?	Date:			
If you have a coil or implant approximately what date was it fitted?	Date:			
If you have depot injections when was your last one?	Date:			
Have you have a recent smear?	Date:		Normal / Abnormal	

CARER INFORMATION

If you are a Carer, please state the name / address / phone number of the person YOU care for:	**Person cared for contact details**	
If you have a Carer, please state their name / address / phone number and sign here if you wish us to disclose information about your health to you Carer.	**Carer contact details**	
	Signed	**Date**
Do you have a 'Living Will' (a statement explaining what medical treatment you would not want in future)?	YES / NO	**If 'YES' please bring a written copy of it when registering at the Practice.**

YOUR LIFESTYLE

EXERCISE: Please circle which of these terms best describes how much exercise you take on a regular basis.			
None	Light	Moderate	Heavy
Body Measurements	Height	Weight	Waist Circumference

YOUR SMOKING STATUS

Are you currently a smoker?	Yes / No	If YES how much do you smoke in a week?	
Have you ever been a smoker?	Yes / No	Date stopped?	
If you are currently a smoker and would like to stop, please ask for information about local smoking cessation services.			

YOUR ALCOHOL COMSUMPTION

Please circle your answers below.						
How often do you have a drink containing alcohol?	N/A	Never	Monthly or Less	2-4 Time 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?	N/A	1-2	3-4	5-6	7-9	10+

How often in the past year have you found that you were unable to stop drinking when you have started?	N/A	Never	Less Than Monthly	Monthly	Weekly	Daily or almost daily
How often in the past year have you failed ot do what was normally expected of you because of alcohol?	N/A	Never	Less Than Monthly	Monthly	Weekly	Daily or almost daily
Has a relative/friend or Healthcare Professional been concerned about your drinking or suggested you cut down?	N/A	No	Yes but not in the past year	Yes, during the past year	Weekly	Daily or almost daily

DEPRESSION SURVEY

In the last two weeks, how often have you been bothered by any of the following problems? (Please circle one statement for each question)				
Little interest or pleasure in doing things?	Not At All	Several Days	More than half	Nearly every day
Feeling down, depressed or hopeless?	Not At All	Several Days	More than half	Nearly every day
Trouble falling or staying asleep, or sleeping too much?	Not At All	Several Days	More than half	Nearly every day
Feeling tired or having little energy?	Not At All	Several Days	More than half	Nearly every day
Poor appetite or overeating?	Not At All	Several Days	More than half	Nearly every day
Feeling bad about yourself – or that you are a failure or have let yourself or your family down?	Not At All	Several Days	More than half	Nearly every day
Trouble concentrating on thing, such as reading a newspaper or watching television?	Not At All	Several Days	More than half	Nearly every day
Moving or speaking so slowly that people noticed? Or being restless, moving around more than usual?	Not At All	Several Days	More than half	Nearly every day
Thoughts that you would be better off dead, or of hurting yourself in some way?	Not At All	Several Days	More than half	Nearly every day

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. By expressing your interest, you will be helping us to plan ways of involving patients within the practice. It will also mean we can keep you informed of opportunities to give your views and keep you up to date with developments at the Practice.	
Yes, I am interested in becoming involved in the Virtual Practice Patient Participation Group (as a virtual member you will only be contacted by email). ***(If you are interested please tick the box)***	

Patients Signature:	
Date:	
Signature on Behalf of Patient (if applicable)	
Relationship to Patient (if applicable)	

Patient checklist for completing the registration form:

- ☐ **NHS Number (can be obtained from previous GP surgery)**
- ☐ **Contact number and email address**
- ☐ **Previous GP's details**
- ☐ **Full previous address**
- ☐ **Copy of your prescription counterfoil (if you are on regular medication)**
- ☐ **Signed and dated New Patient Registration Form**
- ☐ **Return form to Practice with Photographic ID and additional proof of address**

OFFICE USE ONLY:

Form Received and Checked by:		
Identity Verified by:	***Date:***	***ID Shown:*** ☐ ***Passport*** ☐ ***Driving Licence*** ☐ ***Birth Certificate*** ☐ ***Bank Statement*** ☐ ***Utility Bill*** ☐ ***Marriage Certificate*** ☐ ***Other***