**REGISTRATION HEALTH QUESTIONNAIRE**

*To register with the Practice please complete this questionnaire as fully as possible. The information will help the doctor to make an initial assessment of your health which will help in your future treatment. If you prefer to have an appointment with one of our healthcare assistants, please ask at reception.*

For Amin Use Only:

ID documentation verified: Yes No Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surname:………………………………………………… Forename:……………………………………………..

Address:………………………………….…………………………………………………………………………………

……………………………………………………………………. Postcode:……………………………………………..

Date of Birth: ……………………………….. Marital Status: …………………………………………..

Home Tel:……………………………………………… Mobile:……………………………………………………

Email:………………………………………………………

I would like online access, to book and cancel appointments [ ]

I would like online access to Immunisations/ Medication/ Allergies [ ]

(details will follow by post)

I would like to receive appointment reminders and practice communications by text message [ ]

My mobile telephone number is ………………………………………………………………………

**For Children Under 18 Only:**

Name of Parent or Guardian: …………………………….………… Relationship: ………………………

# 1. MEDICAL HISTORY

Please give details of any hospital treatment as an in-patient:

………………………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………………

Please give details of any chronic medical conditions e.g. Diabetes Date of Onset

…………………………………………………………………………. ………………

………………………………………………………………………………………….

………………………………………………………………………………………….

………………………………………………………………………………………….

…………………………………………………………………………………………. ………………………………………………………………………………………….

(please use reverse if needed)

**2. MEDICATION**

Please give details of any medication taken (prescribed or otherwise including regularly used vitamins, supplements or chemist purchases. (Continue on back page if required.)

Name of drug: ……………………………………

Dosage: ……………………………………………….

Name of drug: ……………………………………

Dosage: ……………………………………………….

**3. ALLERGIES** – Please give details of allergies to foods or other substances: ………………………………………………………………………………………………………………

4. ETHNICITY

This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

………………………………………………………………..

*If Registering a Child Please Go To Q16*

5. FAMILY HISTORY

Is there any of the following in your family? *(father, mother, brother, sister)*

Heart Disease (heart attacks, angina) Yes [ ]  No [ ]

If yes, which family member? ………………………………………………………………………………

How old were they when its started? …………………………………………………………………

Diabetes Yes [ ]  No[ ]

If yes, which family member? ………………………………………………………………………………

High Blood Pressure? Yes [ ]  No [ ]

If yes, which family member? ………………………………………………………………………………

Glaucoma? Yes [ ]  No[ ]

If yes, which family member? ………………………………………………………………………………

Stroke? Yes[ ]  No[ ]

If yes, which family member? ………………………………………………………………………………

High Cholesterol? Yes [ ]  No [ ]

If yes, which family member? ………………………………………………………………………………

Cancer? Yes[ ]  No[ ]

If yes, which family member? ………………………………………………………………………………

Site of cancer? ………………………………………………………………………………………

6. IMMUNISATIONS

Date of last Tetanus ………………………………………………………………………………………………

### **7. SMOKING**

## Do you smoke? Yes [ ]  No [ ]

If yes how many:

Cigarettes per day ……… Cigars per day……. Ounces of tobacco per day………

How old were you when you started smoking? …………………………………………………..

*If you are a smoker and would like support with quitting, we have Stop Smoking Advisors in Surgery who can help. Please ask for an appointment at reception.*

**8. EX SMOKERS**

How much did you smoke per day? .……………………………………………………………………..

### **9. ALCOHOL CONSUMPTION**

## Please circle the answers that apply to you

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Questions | 0 | 1 | 2 | 3 | 4 |
| How often do you have a drink that contains alcohol? | Never | MonthlyOr less | 2-4 timesper month | 2-3 timesper week | 4+ timesper 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 thanMonthly | Monthly | Weekly | Daily orAlmost daily |

# 10. EXERCISE

Do you take regular exercise? Yes [ ]  No [ ]

If yes, what type of exercise? ……………………………………………………………………………

How many times per week? ……………………………………………………………………………………

## **11. CARERS**

## Are you a carer for someone who is sick or frail? Yes [ ]  No [ ]

Please give name and date of birth of this relative …………………………………………

**12. OCCUPATION** ………………………………………………………………………………

## **12b.** Have you ever served in the military? Yes [ ]  No [ ]

**13. WEIGHT in Kg (approx.)** ………………………………………………………………………………………

**14.** **HEIGHT in cm**………………………………………………………………………………………………

#### 15. FEMALE PATIENTS ONLY

Date of most recent cervical smear: …………………………………………………………………..

Result of most recent smear: ……………………………………………………………………………….

***Q16 Please complete where applicable***

**16. IMMUNISATIONS** (please state date given)

**Usually During First Year of Life**

1st Diptheria / Tetanus / Whooping cough / Hib+Polio **Date ………………**

1st Pneumococcal **Date ………………**

1st Rotavirus **Date ………………**

1st Meningitis B **Date** ………………

Please state where immunisation performed: GP or Health Clinic

2nd Diptheria / Tetanus / Whooping cough / Hib+Polio **Date ………………**

2nd Rotavirus **Date ……………..**

2nd Meningitis B **Date** ……………….

3rd Diptheria / Tetanus / Whooping cough / Hib+Polio **Date ………………**

**Usually During Second Year of Life**

Mumps / Measles / Rubella (MMR) **Date ……………….**

Hib/ MenC **Date ……………….**

3rd Pneumococcal  **Date ……………….**

3rd Meningitis B **Date** …………………

**3 years 4 months onwards**

Tetanus / Diptheria / Polio (pre school booster) **Date ……………….**

Mumps / Measles / Rubella (MMR) Booster Dose **Date ……………….**

**13 to 18 years**

Meningitis ACWY **Date……………….**

**Adults aged 65 years and over or in a clinical risk group**

Pneumococcal Polysaccharide Vaccine (Pneumovax) **Date …………...**

**Adults aged 70-80 years and over in a clinical risk group**

Shingles **Date ……………….**

**Your Data Matters**

**You can choose whether your confidential patient information is used for research and planning.**

**How your data is used**

Your health and care information is used to improve your individual care. It is also used to help us research new treatments, decide where to put GP clinics and plan for the number of doctors and nurses in your local hospital. Wherever possible we try to use

data that does not identify you, but sometimes it is necessary to use your confidential patient information.

**Making your data opt-out choice**

You can choose to opt out of sharing your confidential patient information for research

and planning. There may still be times when your confidential patient information is

used: for example, during an epidemic where there might be a risk to you or to

other people’s health. You can also still consent to take part in a specific research project.

**What is confidential patient information?**

Confidential patient information identifies you and says something about your health, care or treatment. You would expect this information to be kept private. Information that only identifies you, like your name and address, is not considered confidential patient information and may still be used: for example, to contact you if your GP practice is merging with another.

**Will choosing this opt-out affect your care and treatment?**

No, your confidential patient information will still be used for your individual care. Choosing to opt out will not affect your care and treatment. You will still be invited for screening services, such as screenings for bowel cancer.

**You can change your choice at any time.**

For more detailed information regarding this please ask a member of our team for a patient information leaflet or to make your choice visit **nhs.uk/your-nhs-data-matters** or call

**0300 303 678**.