|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **ILLNESSES, ACCIDENTS & OPERATIONS**  Please list, giving dates of all serious illnesses  Accidents and Hospital admissions or operations | | | | **MEDICATIONS**  Please list any medications you are taking including ones you buy  such as aspirin, vitamins, homeopathic etc. | | | |
| **ARE YOU ALLERGIC TO ANYTHING?** Please give details | | | | **Do you smoke?** | | **YES/NO** | |
| **Have you ever smoked?** | | **YES/NO** | |
| **If you answered YES to either question:** | | | |
| **FAMILY HISTORY** | | | | How many cigarettes/ tobacco packs etc. do or did you smoke a year? | |  | |
| Do you or anyone in your family have any of the following: | | | | How long have you been smoking (years)? | |  | |
| *(Please give relationship of family member e.g.: Maternal or Paternal Grandmother* | | | | Do you use electronic cigarettes? | | **YES/NO** | |
| */ Grandfather)* | | | | Date you stopped smoking (if applicable) | |  | |
|  | | | | **DO YOU WANT HELP TO GIVE UP SMOKING?** | | **YES/NO** | |
|  | **YOU** | **FAMILY** | **WHO** | Please ask about the STOP SMOKING CLINIC | | | |
| **DIABETES** | YES / NO | YES / NO |  |  | | | |
| **HIGH BLOOD PRESSURE** | YES / NO | YES / NO |  | 1. **How often do have a drink containing alcohol?** | | | |
| **HEART ATTACK** | YES / NO | YES / NO |  | 0 | Never | | 🞏 |
| **STROKE** | YES / NO | YES / NO |  | 1 | Monthly or less | | 🞏 |
| **ASTHMA** | YES / NO | YES / NO |  | 2 | Two to four times a month | | 🞏 |
| **EPILEPSY OR FITS** | YES / NO | YES / NO |  | 3 | Two to three times a week | | 🞏 |
| **SKIN DISEASE** | YES / NO | YES / NO |  | 4 | Four or more times a week | | 🞏 |
| **NERVOUS DISORDERS** | YES / NO | YES / NO |  | 1. **How many drinks containing alcohol do you have on a typical day when you are drinking?** | | | |
| **CANCER** | YES / NO | YES / NO |  |
| **KIDNEY DISEASE** | YES / NO | YES / NO |  | 0 | 1 or 2 | | 🞏 |
| **DEPRESSION** | YES / NO | YES / NO |  | 1 | 3 or 4 | | 🞏 |
| **OTHER** | | | | 2 | 5 or 6 | | 🞏 |
| **IMPORTANT:** | | | | 3 | 7 or 9 | | 🞏 |
|  | | | | 4 | 10 or more | | 🞏 |
| ***Please*** *book for a New Patient Health Check with nurse* | | | | 1. **How often do you have six or more drinks on one occasion?** | | | |
|  | | | | 0 | Never | | 🞏 |
| ***Staff- have you made the patient an appointment***  YES / NO | | | | 1 | Less than monthly | | 🞏 |
|  | | | | 2 | Monthly | | 🞏 |
| ***Do you have a DISABILITY?*** YES / NO (If yes, please provide details below) | | | | 3 | Weekly | | 🞏 |
|  | | | | 4 | Daily or almost daily | | 🞏 |
|  |  | |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **WOMEN ONLY** | | **SQUIRES LANE MEDICAL PRACTICE - NEW PATIENT REGISTRATION FORM** | | | | | | | |
| Do you use contraceptives? E.g. the pill, condoms etc. | | ***Please complete ALL parts of this form*** | | | | | | | |
| *Please give details* | | NAME: |  | | | | | | |
| CERVICAL SMEAR TEST (Please complete the following details) | | Mobile No: |  | | | | | | |
| DATE OF LAST TEST: |  | Work No: |  | | | | | | |
| PLACE WHERE TEST WAS DONE: |  | Home No: |  | | | | | | |
| RESULT OF TEST: |  | e-Mail: |  | | | | | | |
| Have you had a mammogram? | YES/NO  Date | **I consent to being contacted via SMS text messages, including information about appointments and test results** YES NO | | | | | | | |
| Have you had a hysterectomy? | YES/NO  Date | Date of Birth: |  | | | | Age: | |  |
| PLEASE GIVE DATES OF: | | Married 🞏 | Single 🞏 | Divorced 🞏 | Widowed 🞏 | | | Co-habiting 🞏 | |
| Live Births: |  | Occupation: | | | | | | | |
| Terminations: |  | Place of Birth |  | | | | | | |
|  | | Do you need an Interpreter YES/NO | | | | | | | |
|  | | Which language? | | | | | | | |
| **STAFF USE ONLY**  **Tick information collected / added onto system:**  🞏 Inform patient of named GP and code into EMIS (67DJ / 9NN60)  🞏 Code Alcohol (38D4) onto EMIS  🞏 Code Smoking Cessation Advice (8CAL) onto EMIS  🞏 Check passport for EACH Patient without an NHS Number (take copy of passport and UK Visa)  🞏 Ensure online access form is completed **and form of ID ticked**  🞏 Smear booked for women over 25yrs of age, if overdue  🞏 Red book collected / photocopied, for all children under 7  🞏 Offer, newly register child, health check with nurse and code (6781)  🞏 Summary Care OPT-OUT form complete + code added (9NDO)  🞏 Care Data OPT-OUT form complete + codes added (9NU0 and 9NU4)  🞏 CARER or Cared For – get relevant details and create TASK for Office  **THANK YOU** | | Are you a **CARER** or is someone a carer for you? Delete as appropriate  I am a carer / I have a carer / neither | | | | | | | |
| **Ethnic Origin** | | | | | | | |
| White British | African | | | Indian/British Indian | | | |
| White Irish | Black Caribbean | | | Parkistani/British Pakistani | | | |
| Other white | Mix white/black Caribbean | | | Bengali/British Bengali | | | |
| Chinese | Mix white/black African | | | Mix white/Asian | | | |
| Other | Other black | | | Other Asian | | | |
| **NEXT OF KIN** (someone we can contact in an emergency) | | | | | | | |
| Name: |  | | | | | | |
| Telephone |  | | | | | | |
| Mobile |  | | | | | | |
| Email |  | | | | | | |
| Relationship |  | | | | | | |