The Argyle Surgery

New Patient Registration Questionnaire

Welcome to our surgery! Thank you for taking the time to complete this questionnaire in BLOCK CAPITALS

PERSONAL DETAILS	Have you previously been registered at this practice before? ☐ Yes ☐ No
Name: Mr/Mrs/Miss/Ms/Dr/Other	Gender: ☐ Male ☐ Female
Address: Postcode:	Date of Birth: / /
Home Tel:	Mobile:
Email:	NHS No (if known):
Main Language (if not English):	Do you need an interpreter? ☐ Yes ☐ No
Town of Birth:	Country of Birth:

Do you need help with mobility/ hearing/ speaking? (tick all that apply)

☐ Wheelchair ☐ Walking Aid ☐ Hearing Aid ☐ British Sign Language ☐ Makaton sign language

☐ Lip reading ☐ Large print ☐ Braille ☐ Other (please state)

ETHNIC ORIGIN Please tick one box only (national 2011 census categories)

White	**Mixed/Multiple Ethnic**	**Asian / Asian British**	**Black/African/Caribbean/ Black British**	**Other Ethnic Group**
☐ English/Welsh/Scottish /Northern Irish /British	☐ White and Black Caribbean	☐ Indian ☐ Pakistani	☐ African	☐ Arab
☐ Irish	☐ White and Black African	☐ Bangladeshi	☐ Caribbean	☐ Other Ethnic (specify) ....
☐ Gypsy or Irish Traveller	☐ White and Asian	☐ Chinese	☐ Other Black (specify)	☐ I do not wish to answer this question
☐ Other White (specify)	☐ Other Mixed (specify)	☐ Other Asian (specify)		

Please state all countries you have lived in or visited for periods of greater than 6 months:

Country:	Dates/Year if known

NEXT OF KIN	Name: Tel: Relationship:

Please list other relatives of your home who are registered with us

Relationship:	Name:	Date of Birth:

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Looking after someone	
Are you looking after someone? ☐ Yes ☐ No Let us know if you are looking after someone who is ill, frail, disabled or has mental health and/or emotional support needs, or substance misuse problems.	
Is someone looking after you? ☐ Yes ☐ No Let us know if a family member, friend or neighbour looks after you. If yes, they are your carer. You are welcome to invite your carer to accompany you to visits at the practice	
Carer's name: Address of carer: Telephone number of carer:	Relationship to you:

Employment Status
Are you currently employed? If so please specify whether: ☐ Full-time ☐ Part-time ☐ Self-employed
If you are not employed, please indicate what best describes you: ☐ Retired ☐ Student ☐ House wife/ Home maker/ House husband ☐ Unemployed ☐ Other (please state)
If returning from the Armed Forces please state which below ☐ Army ☐ Royal Navy ☐ Royal Air Force

MEDICAL HISTORY	Please tick if you have ever suffered or been treated for any of the following:				
☐ Asthma	☐ Epilepsy	☐ Diabetes	☐ High Cholesterol	☐ Mental Illness	☐ Cancer of:
☐ COPD	☐ Stroke	☐ High BP	☐ Heart Disease	☐ Thyroid Disorder	☐ Other:
If you have any chronic or significant medical condition, please book a New Patient appointment to discuss it further					

FAMILY HISTORY	Please state if any family member has suffered from any of the conditions listed above:				
Illness/Condition	1.	2.	3.	4.	5.
Family member					

Aged diagnosed					

MEDICATION	Any allergies to any drugs/medicines?
Are you taking regular medication? ☐No ☐Yes If Yes, please book a New Patient Registration appointment. Please bring to this appointment all your medication (with packaging) and/or your repeat medication request slip from your previous GP (if applicable)	

VACCINATIONS			
Date	Immunisation	Date	Immunisation

FEMALE PATIENTS ONLY	Are you currently pregnant? ☐Yes ☐No If yes, please book an appointment
If aged 25-64 yrs old, when did you last have a cervical smear test? Where was it done? What was the result?	

LIFESTYLE	Height (approx)? cm	Weight(approx)? kg
Do you smoke? ☐Never Smoked ☐Ex-smoker ☐Smoke …… cigarettes daily If you would like to stop, please ask reception for details of Smoking Cessation Services.		
Any BP check within the past year? ☐Yes ☐No If yes, do you know what was the BP reading? /		
How many hours of exercise (which makes your heart race) do you take in an average week? hours		
Do you have any special diet? ☐No ☐ Vegetarian ☐Vegan ☐Other (specify)		

ALCOHOL	Alcohol consumption is measured in units, which is explained in the diagram below.

This is **one unit**...

Half pint of regular beer, lager or cider

One very small glass of wine

One single measure of spirits

One small glass of sherry

One single measure of aperitifs

...and each of these is **more than one unit**...

2
A pint of regular beer, lager or cider

3
A pint of premium beer, lager or cider

1.5
Alcopop or a can/bottle of regular lager

2
440ml can of premium lager or strong beer

4
440ml can of super strength lager

2
175mm glass of wine

9
Bottle of wine

Please have a look at this diagram and then answer the questions on the next page.

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Total AUDIT Score (Questions 1 – 10):

Questions about your Alcohol Consumption	Scoring System 0	1	2	3	4	Your score
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
2. How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
3. How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
If your total score for the above 3 questions is 4 or less, then you do not need to complete the questions below						
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

If you are concerned about your consumption of alcohol, please book an appointment with a doctor or a nurse. Alternatively you can call RISE on 0800 195 8100

Please turnover the page

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence

Sharing Your Medical Record

Medical Record Sharing allows your complete GP medical record to be made available to authorised healthcare professionals involved in your care. You will always be asked your permission before anybody looks at your shared medical record.
If you don't want to share your GP record tick here: ☐

Summary Care Record contains details of your key health information – medications, allergies and adverse reactions. They are accessible to authorised healthcare staff in A&E Departments throughout England. You will always be asked your permission before anybody looks at your Summary Care Record.
If you don't want to have a Summary Care Record tick here: ☐

The Care.data Programme Collates information about you and the care you receive. It links information from all the different places where you receive care, such as your GP, hospital and community services, to help them provide a full picture of your medical needs and the care you are receiving. This data is made available to NHS Commissioners so that they can design integrated services and is shared with third parties for research purposes.

☐ **I wish to OPT OUT from my Personal Confidential Data being shared outside my *GP practice*:**

☐ **I wish to OPT OUT from my Personal Confidential Data being shared with *third parties*:**

Patient Participation Group (PPG)

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 that suit you. It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice.
If you are interested in getting involved in the PPG, please tick yes in the box below and we will contact you with further details.

☐ ***Yes*** I am interested in becoming involved in the PPG	☐ ***No*** I am not interested in becoming involved in the PPG

Online Services

You can now do the following online or via the SystmOnline app:

- Book and cancel appointments, order repeat prescriptions,
- view your Detailed Medical Record (by application)

IT WILL BE YOUR RESPONSIBILITY TO KEEP YOUR LOGIN DETAILS AND PASSWORD SAFE AND SECURE. IF YOU KNOW OR SUSPECT THAT YOUR RECORD HAS BEEN ACCESSED BY SOMEONE THAT YOU HAVE NOT AGREED SHOULD SEE IT, THEN YOU SHOULD CHANGE YOUR PASSWORD IMMEDIATELY.

☐ ***Yes*** I'd like to register for online services	☐ ***No*** I don't want to register for online services

Other Information

Do you have a "***Living Will***" or "Advanced Directive"? (A statement explaining what medical treatment you would not want in the future)?	☐Yes ☐No	***If "Yes"***, can you please bring a written copy of it to your first appointment?
Have you nominated someone to speak on your behalf (***e.g. a person who has Lasting Power of Attorney***)? ☐Yes ☐No	***If "Yes", please state*** their Name: Address:	

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	Phone number:

CHECKLIST

Thank you for completing this form. Please check you have completed all sections where possible.
Please ensure that you bring the following with you to the surgery to complete your registration:

1. **Completed & Signed New Patient Registration Questionnaire** (this form!) ☐
2. **Completed & Signed GMS1 Form** ☐
3. **Photo Proof of ID** - e.g. Passport, Photo Driving License or Photo ID card ☐
4. **Proof of Address** – Must be in your name and dated within the past 3 months ☐
   – One of the following: Bank statement, Utility Bill (Gas, Electricity, Water), Council Tax, Tenancy Agreement or Landline Phone Bill (Mobile phone bills are not accepted)
5. If possible, your **Immunisation Records** – usually the Personal Child Health Record ("Red Book") ☐
6. If possible, your **NHS Card** – usually shows your previous GP and your NHS Number ☐
7. If relevant, your **Repeat Medication Request Slip** from your previous GP ☐

Please book a New Patient appointment if you are on any regular medication or have any chronic or significant medical condition.

Please request a copy of the Practice Leaflet if you have not already received it. Alternatively you can also find more information at our practice website http://www.argylesurgery.nhs.uk/

I confirm that I have completed this form as accurately and honestly as possible and would like to apply to be registered as a patient at this practice

Signature: **Date: / /20**

OFFICE USE ONLY	Need Appt? ☐Yes ☐No TB screening? ☐Yes ☐No			**Staff Initials:**
Photo ID	☐ Passport	☐ Driving licence	☐ Identity card	☐ Other
Proof of Address	☐ Utility Bill	☐ Tenancy Agreement	☐ Bank Statement	☐ Other

<Organisation Address>
<Organisation Details>