**NEW PATIENT REGISTRATION FORM**

**You will be registered under: Dr M Garg**

All information will be treated in the strictest confidence and is for your GP’s records only

**Registration cannot be accepted unless this information is provided**

| Surname/Last/Family Name: | | Forename/First Name(s): | | | | | Previous Names: | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Address:  Postcode: | |  | | | | | **\*IMPORTANT\***  **Height (cm)** | |  |
| **\*IMPORTANT\***  **Weight (kg)** | |  |
| Date of Birth: | | | | | | | | | |
| Home Telephone Number: | | | Mobile Telephone Number: | | | Work Telephone Number: | | | |
| Do you give consent for the practice to contact you via text message? Yes  No | | | | | | | | | |
| No of children living with you: | | | | | Other dependents living with you: | | | | |
| Place/Country of Birth:  Ethnicity: | | | First Language:  Interpreter Required: YES / NO | | | Occupation/Unemployed/Retired | | | |
| **Please tick one of the following as appropriate** | | | | | | | | | |
| Single | Married | | | | Co-habiting | | | Widowed | |
| **FAMILY HISTORY** Have you or your family had any of the following conditions? | | | | | | | | | |
|  | **Yourself** | | | | **Your family –** Please state family member, eg Mother, Brother, etc and give any relevant details | | | | |
| **Yes** | | | **No** |
| Asthma |  | | |  |  | | | | |
| Diabetes |  | | |  |  | | | | |
| High blood pressure |  | | |  |  | | | | |
| Heart problems |  | | |  |  | | | | |
| Stroke |  | | |  |  | | | | |
| Epilepsy/fits |  | | |  |  | | | | |
| Skin disorders |  | | |  |  | | | | |
| Nervous disorders |  | | |  |  | | | | |
| Allergies(inc medicines) |  | | |  |  | | | | |
| Congenital diseases |  | | |  |  | | | | |
| Cancer |  | | |  |  | | | | |
| Have you had any illness/operations not mentioned above? (Please give dates where applicable).  Also state if you have any other disabilities | | | | | | | | | |
| Do you take any medicines/tablets regularly? If so, give details, ie name, dose, time of day taken | | | | | | | | | |
| If you take regular medication we recommended nominating a pharmacy. If there is a pharmacy near you please provide their **name and address.**  If none is chosen we will nominate the nearest pharmacy to you. This can be changed at a later date. | | | | | | | | | |
| Please state which immunisations you have had and when:  **\*CHILDREN MUST PRODUCE THEIR RED BOOK TO BE REVIEWED BY OUR NURSES\*** | | | | | | | | | |

**NEW PATIENT REGISTRATION FORM – Continued**

**THE FOLLOWING QUESTIONS MUST BE ANSWERED**

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| Q1 Do you drink alcohol? | YES  NO |
| --- | --- |
| Q2 If you drink, how many units per week?  (NB; 1 unit = ½ beer, 1 small wine, 1 single spirit)  (1/2 strong lager = 2 units) |  |
| Q2 Do you smoke?  (Cigarettes, tobacco & electronic cigarettes) | YES  NO |
| Q3 If yes, how many daily?  \***DOCTORS ADVICE WOULD BE TO STOP SMOKING.\***  **INFORMATION ON STOP SMOKING CLINICS AVAILABLE FROM RECEPTION** |  |
| Q4 Have you ever smoked? | YES  NO |
| Q5 If yes, how many did you smoke? |  |
| Q6 If you have stopped smoking, please state what year you stopped |  |
| Q7 Do you need advice about giving up? | YES  NO  **PICK UP A LEAFLET FROM RECEPTION** |

| **WOMEN** We would expect to see women for contraceptive advice and blood pressure checks  (contraceptive pill – yearly) | | |
| --- | --- | --- |
| What form of contraception do you use? | |  |
| When did you last have a cervical smear? | Where? | Result? |

| Next of Kin Name: Relationship: |
| --- |
| Next of Kin Address: |
| Next of Kin Contact Telephone Number: |

**PLEASE SIGN YOUR NAME:** ………………………………………………………..

**DATE:** ……………………………………………………………………………………

**Your named GP will be Dr M Garg**

**Thank you**