CLEVELEYS GROUP PRACTICE - NEW PATIENT REGISTRATION

FOR OFFICE USE ONLY.

ADW

LS

RECEPTION

SCRIPTS

ADMIN

Name: …………………………………………… Date of Birth ………/………/…………

Address:………………………………………………………………………………………………

………

Telephone No : ……………………

Name, Address, Tel No of previous GP: ……………………...

………

Next of kin and contact number:……………………………………………………..

Height: …………………………. Weight: ……………………………..

DO YOU SUFFER FROM ANY OF THE FOLLOWING MEDICAL CONDITIONS?

Diabetes	☐	Asthma	☐
COPD	☐	Heart Condition	☐
Stroke	☐	High Blood Pressure	☐
Epilepsy	☐	Mental Health	☐
Thyroid	☐	Cancer	☐

SMOKING STATUS

Do you smoke? Yes ☐ Never ☐ Ex ☐

If yes, how many per day? ………. If ex-smoker when did you stop ? ………………..

For help with stopping smoking ring: NHS STOP SMOKING SERVICE: 01524 845145

ARE YOU CURRENTLY ATTENDING A HOSPITAL OUT PATIENT CLINIC?
IF SO PLEASE GIVE DETAILS.

………

PLEASE LIST MEDICATIONS YOU ARE CURRENTLY TAKING
(if possible please attach a list from previous GP).

Name	Strength	Dose
………………………………………………..	………………………..	………………
……………………………………………….	……………………….	………………
……………………………………………….	………………………..	………………
……………………………………………….	………………………..	………………
……………………………………………….	………………………..	………………
………………………………………………	……………………….	………………

FEMALES - PLEASE GIVE THE DATE OF YOUR LAST CERVICAL SMEAR AND RESULT IF KNOWN.

Date:…………………………………. **Result:**……………………………………..

New Patient Questionnaire continued overleaf - PTO

ALCOHOL QUESTIONNAIRE

	0	1	2	3	4	Score
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many standard drinks containing alcohol do you have when you are drinking?	1 or 2	3 or 4	5 or 6	7 or 8	10 or more	
3. How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Please note: a standard drink is:- half a pint of beer, a single measure of spirits, 125mls of 8% wine, 50mls of sherry						

CARER QUESTIONNAIRE

Are you a main carer for someone with a Chronic Disease such as any of those stated overleaf?

Yes ☐ No ☐

If yes is the person registered at this practice ? Yes ☐ No ☐

Please state the name and date of birth of the patient cared for :………………………………………….

Date of Birth ………/………./…………

Do you agree to being registered on our system as a carer? Yes ☐ No ☐

Signature: ………………………………………………………………….

PATIENT ETHNIC QUESTIONNAIRE

This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act

Please indicate your ethnic origin. 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.

A. White

	British
	Irish
	Any other white background please write below

B Mixed

	White and Black Caribbean
	White and Black African
	White and Asian
	Any other mixed background please write below

C Asian or Asian British

	Indian
	Pakistani
	Bangladeshi
	Any other Asian background please write below

D Black or Black British

	Caribbean
	African
	Any other black background please write below

E Chinese

	Chinese
	Any other please write below