

YOUR DETAILS: (Please Circle)  
Title: MR / MRS / MISS / MS / OTHER   
Full Name:   
  
………………………………………………………………………………………………….Date of Birth: D D / M M / Y Y Y Y

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

…………………………………………………… Post Code: ………………………….

Telephone No: …………………………………

Mobile Telephone No: ………………………………………………………………

SMS Consent: YES / NO

Email address: ….………………..........................................................

Ethnicity: …………………………………………………………………………………..

NEW PATIENT REGISTRATION FORM & HEALTH QUESTIONNAIRE

Please complete this form as thoroughly as possible.

INTERNAL USE ONLY   
(If Online Access has been requested)

Patient’s photo ID seen? YES / NO

Type of photo ID seen:

………………………………………………………………

STAFF SIGNATURE:

………………………………………………………………

CARER INFORMATION (Please Circle)  
ARE YOU / DO YOU HAVE a carer? YES / NO

IF YES, name of CARED FOR PERSON / CARER (please circle):

…………………………………………………………………………………………

ONLINE ACCESS  
PATIENT ONLINE is a free service that allows you to:

* Book or cancel appointments online
* Renew or order repeat prescriptions online
* View your GP record online

You will be able to complete these actions using a computer, tablet or   
smart phone rather than having to phone or visit your practice.

Would you like to register for Patient Online services? YES / NO

IF YES, we will provide you with a username and password once   
a valid photo ID has been seen.

SUMMARY CARE RECORDS & RECORD SHARING  
The NHS in England is using an electronic record called the Summary Care Record (SCR) to support patient care.

The Summary Care Record is a copy of key information from your GP record. It provides AUTHORISED CARE PROFESSIONALS with faster, secure access to essential information about you when you need care.  
**Summary Care Records improve the safety and quality of your care**.  
  
Would you like to **OPT OUT** of Summary Care Records? YES / NO

If you visit somewhere else for any sort of care, such as a hospital emergency department, or a physiotherapist etc, we would like to share your care details with them. Please be aware this is with **authorised care professionals only.**

Share your records **OUT** to them? YES / NO Share your records **IN** from them? YES / NO

Please be aware you can contact the practice to change your decisions at any time.

NEXT OF KIN DETAILS: (Please Circle)  
Title: MR / MRS / MISS

MS / OTHER   
  
Name: ..……………………………………………………………..

Address: .…………………………………………………………..

…………………………….…………………………………………….

Post Code: …………………………………………………………

Telephone No: …………………………………………………..

Mobile Telephone No: ………………………………………

Relationship (IE. Husband / Partner / Mother):

..…………………………………………………………………………

Can we contact and discuss details of your care with your Next of Kin?

YES / NO

This decision can be changed at any time.

**The Old Station Surgery**

HEALTH QUESTIONNAIRE  
Do you suffer from any of the following? (Please Circle)  
  
HEART DISEASE- Heart Attack YES / NO  
 Angina YES / NO  
  
BLOOD PRESSURE- High YES / NO  
 Low YES / NO

STROKE S YES / NO

DIABETES YES / NO

ASTHMA YES / NO

COPD YES / NO

HIGH CHOLESTEROL YES / NO

STOMACH OR DUODENAL ULCERS YES / NO

Any other conditions or family history that we need to be aware of: (eg. Family history of cancer)

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

…………………………………………………………………………………………….

…………………………………………………………………………………………….

ARMED FORCES

Please circle if you have served in one of the following:

ARMY / ROYAL NAVY / ROYAL AIR FORCE

HEALTH CHECK

All patients who are on regular medication for the treatment of a chronic disease such as asthma, COPD or diabetes are required to attend a health check.

If you are not on regular medication and **don’t require** / **wish** to have a health check, please tick here:

PATIENT SIGNATURE: ...………………………………………………………………………………………………………  
  
Today’s Date: ……………………………………………………………………………………………………………………..

EXERCISE

Do you exercise? YES / NO

IF YES, what type and how often? .....................................................................................

…………………………………………………………………………………

SMOKING

Do you smoke? YES / NO

IF YES, how many? …..……………………………… per day

IF NO, have you ever smoked? YES / NO

When did you stop? ………………………………………………

ALCOHOL

Do you drink alcohol? YES / NO

IF YES, how much do you drink in an average week?

……………………………………………………… units per week

MEDICAL INFORMATION  
Please list any serious ILLNESSES / OPERATIONS / ACCIDENTS / DISABILITIES:

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

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

Please list any current medication that you are taking, and the amount: (Please also submit the medication list part of your most recent prescription if possible) ………………………………………………………………………………………………………………………………………………………………………………………..

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

Are you allergic to any medications? YES / NO

IF YES, which ones? …………………………………………………………………………………………………………………………………………………………