



New Patient Registration Form

Please complete ALL of this confidential questionnaire.

Please complete in BLOCK CAPITALS and tick the boxes as appropriate.

If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.

Please complete a separate form for each family member to be registered.

Full Name:				Telephone Number:	
Mr / Mrs / Miss / Ms / Other.....				Work Number:	
Address and Postcode:				Mobile Number:	
				E-mail Address:	
				Can we contact you by text? Y/N	
				Can we contact you by email? Y/N (If yes we will send you a one off verification email that you will need to respond to)	
				Name of next of kin:	
				Relationship of next of kin:	
Date of Birth:				Next of Kin Contact Number:	
Marital Status:		Gender:	Male:	Female:	Other residents of your home:
Occupation:				Previous Surgery:	
Names and Ages of Children:				Previous Postcode:	
				Previous Doctor Telephone No.	
				If applicable, date you first came to live in Britain:	
Your height:	Feet / inches	cm	Your weight:	Stones / lbs.	Kg

If you have not checked your weight in the last 3 months please ask at reception to be weighed							
Your Religion:	C of E	Catholic	Other Christian (state)		Buddhist	Hindu	Muslim
	Sikh	Jewish	Jehovah's Witness		No religion	Other religion (state)	
Your Ethnic Origin: (select one)		White (UK)		White (Irish)		White (Other)	
Caribbean		African		Asian		Other Mixed Background	
Indian / Brit Indian		Pakistani / Brit Pakistani		Bangladeshi / Brit Bangladeshi		Other Asian Background	
Other Black Background		Chinese		Other		Ethnic Category not stated	
Your main or 1 st language Spoken / Understood: (select one)		English	Hindi	Gujurati	Urdu	Bengali /Sytheti	Punjabi
Polish	Ukrainian	French	German	Spanish	BSL	Other: (Please Specify)	
Will you need help in translation during contact with us? Y / N							
Smoking and Exercise:							
Are you currently a smoker?	Yes	No	Have you ever been a smoker?			Yes	No
<i>If you are a smoker we advise you to stop, as there are many health benefits from giving up. If you would like help and information on local smoking cessation services please ask us.</i>							
How often do you exercise?		No. times per week		Type(s) of exercise:			
Your Medical Background:							
What health problems do you have or have had in the past and when?							
What operations have you had and when?							
Do you have any medical problems at present?							
Please list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency)							

If on Warfarin, what type of regular blood test do you have? (Please tick one)	INR*/finger prick blood test <input type="checkbox"/> OR Blood taken from a vein in your arm <input type="checkbox"/>					
If you wish you can nominate a local chemist for your prescriptions to be sent to.	Name and location of chemist:					
Are you able to administer your own medicines?	Yes	No – please detail specific issues (e.g. swallowing, opening containers)				
Are there any serious diseases that affect your parents, brothers or sisters (tick all that apply)	Diabetes	Heart Attack	Heart attack under age of 60	Bowel Cancer		
	Breast Cancer		High Blood Pressure	Asthma	Stroke	
	Thyroid Disorder		Any other important family illness?			
What immunisations have you had? (please tick all that apply)	Diphtheria	Measles	German Measles	Tetanus	Polio	MMR
	Whooping Cough		Pre-school booster	Triple vaccine (Diphtheria, Tetanus & Pertussis) – 3 doses		
Specific Needs: Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:						
Please state any sensory impairment you have (i.e. speech, hearing, sight):						
Are you an 'assistance dog' user?						
Please state any physical disabilities you have:						
Please state any mental disabilities you have:						
Please state any requirements you have to be able to access the Practice premises						
Please state any religious or cultural needs:						
Do you require the help of a translator / interpreter?						
Please state any specific nutritional requirements you have:						
Please state any allergies and sensitivities you have:						
Please state any phobias you have:						

Are you a carer?	Y/N If yes - Who do you care for?
Do you have a carer? If so please state their name / address / phone number and sign here if you wish us to disclose information about your health to your carer.	Carer contact details: Signed: Date:

Do you have a "Living Will" (a statement explaining what medical treatment you would not want in the future)?	Yes / No	<i>If "Yes", Please bring a written copy of it into the surgery so we can add it to your medical records</i>
Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)?	Yes / No	If "Yes", please state their name / address / phone number/relationship:

Summary Care Records

The NHS Summary Care Record is an electronic record of important information about your health. It will be available to health care staff providing your NHS Care.

Are you happy to have a Summary Care Record?	Yes	No
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When we refer you to another health professional for care, we need to give them your medical history so they are aware of your health & any medication you are taking.
If for any reason you do not want us to share your medical history, please inform the doctor at the time of referral.

Do you have online access? If so and you would like to sign up to our online appt booking, medication ordering and viewing your medical records including test results PLEASE ASK AT RECEPTION. They will require photo ID and we then provide you with a username & password.

We also provide an e consult service where you can email your GP for advice – see our website to access this www.litchdonmedicalcentre.co.uk

Patient Participation Group

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 keep you up to date with developments within the Practice.

If you are interested in getting involved, please provide your name, email address and contact telephone number and we will pass these details to the group coordinator.

Name:

Email address:

Telephone number:

Patient signature:	Signature on behalf of patient:	
	Name of person signing on behalf of patient.	

**For more information about the services we offer, please see our website:
www.litchdonmedicalcentre.co.uk**

LITCHDON MEDICAL CENTRE

Please complete this Alcohol Intake Screening questionnaire


Name:

Age:

Date completed:


This brief intervention package is based on the Drink-Less programme originally developed at the University of Sydney as part of a W.H.O. collaborative study.
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UNITS




2

Pint of Regular Beer/Lager/Cider




1.5

Alcopop or Can of Lager




2

Glass of Wine (175ml)



1

Single Measure of Spirits



9

Bottle of Wine

Please follow the instructions and complete the following questionnaire:

ALCOHOL USERS DISORDERS IDENTIFICATION TEST (AUDIT) C

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink that contains alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking	1 - 2	3 - 4	5 - 6	7 - 8	10+	
How often do you have 6 or more standards drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

If your score is 5 or more, please complete the additional questionnaire on the next page.

Additional questionnaire:

Name:

Alcohol Users Disorders Identification Test (AUDIT)

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink that contains alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0-7 = sensible drinking, 8-15 = hazardous drinking, 16-19 = harmful drinking and 20+ = possible dependence

If your score on this sheet indicates hazardous or harmful drinking we would recommend you reduce your alcohol intake. If you would like help please make an appointment with the doctor or nurse.

Thank you for completing all of this questionnaire