

<b>NHS</b>	<b>Family Doctor Services Registration</b>
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**Patient's details**
*Please complete in BLOCK CAPITALS and tick as appropriate*

<input type="checkbox"/> Mr	<input type="checkbox"/> Mrs	<input type="checkbox"/> Miss	<input type="checkbox"/> Ms	Surname
Date of Birth			First names	
NHS No.	Previous surname/s			
<input type="checkbox"/> Male	<input type="checkbox"/> Female		Town and country of birth	
Home Address				
Postcode			Telephone number	

**We will need to trace your previous medical records so please provide us with the following information**

Your previous address in UK	Name of previous doctor while at that address
	Address of previous doctor

**If you are from abroad**

Your first UK address where registered with a GP	
If previously resident in UK, date of leaving	Date you first came to live in UK

**If you are returning from the Armed Forces**

Address before enlisting	
Service or Personnel number	Enlistment date

**If you are registering a child under 5**
 I wish the child above to be registered with the doctor named, for Child Health Surveillance

**If you need your doctor to dispense medicines and appliances \***

<input type="checkbox"/> I live more than 1 mile in a straight line from the nearest chemist	* Not all doctors are authorized to dispense medicines
<input type="checkbox"/> I would have serious difficulty in getting them from a chemist	

 Signature of Patient     Signature on behalf of patient    Date

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# NHS Organ Donor registration

I would like to join the NHS Organ Register as someone whose organs may be used for transplantation after my death.

Please tick as appropriate

Kidneys     Heart     Liver     Corneas     Lungs     Pancreas     Any part of my body

**Signature confirming consent to organ donation**

**Date**

.....

*For more information, please ask for the leaflet on joining the NHS Organ Donor Register*

# NHS Blood Donor registration

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.

Tick here if you have given blood in the last 3 years

**Signature confirming consent to inclusion on the NHS Blood Donor Register    Date**

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*For more information, please ask for the leaflet on joining the NHS Blood Donor Register  
My preferred address for donation is: (only if different from above, e.g. your place of work)*

.....    Postcode: .....

**Please note that Clarendon Lodge Medical Practice are involved in ‘GP2GP’**  
**We would like to draw to your attention, therefore, that if you ever leave and re-register**  
**with a new doctor, your medical notes will be sent electronically to your new GP Practice.**



**NEW PATIENT HEALTH CHECK**

**NEW PATIENT APPOINTMENT WITH OUR PRACTICE NURSE/HEALTH CARE ASSISTANT**

**Patient Address confirmed**

Date of New Patient Check appointment: ..... Time: .....

SL / COL / JA / SH

Welcome to Clarendon Lodge Medical Practice. We would be grateful if a confidential questionnaire could be completed for every new patient registering with the practice.

Once the completed questionnaire is returned, together with the attached ‘family doctor services registration form’, we will be able to proceed with your registration.

We offer all patients, registering with the Practice, a “new patient consultation”. We strongly recommend that you make an appointment because the information gained at this meeting and through the questionnaire, helps us to provide you with the best care and attention possible.

If you are registering a child of 5 or under we do not need a questionnaire completing for them but we do need the form entitled **5 and Under Immunisation Information** returned.

Thank you for your time.

<b>Surname</b>	<b>First Name/s</b>
<b>Title</b>	<b>Known as</b>
<b>Date of birth</b>	<b>Occupation</b>
<b>Ethnic Group</b>	<b>First Language</b>

**Next of Kin**

**Contact telephone number for next of kin**

**Do you have a carer?**  yes  no      If yes please give name and contact telephone number  
 .....  
 .....

**Are you a carer?**  yes  no

## PERSONAL MEDICAL HISTORY

<b>1.</b>	<b><u>Significant Illnesses/Conditions</u></b> (please tick relevant boxes)				
Insulin treated diabetes	<input type="checkbox"/>	Tablet treated diabetes	<input type="checkbox"/>	Diet controlled diabetes	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	Asthma	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	Other chest problems	<input type="checkbox"/>	Other .....	

<b>2.</b>	<b><u>Operation/s</u></b>	<b><u>Date/s</u></b>

<b>3.</b>	<b><u>Other Admission/s to hospital</u></b>	<b><u>Date/s</u></b>

## FAMILY MEDICAL HISTORY

(please tick relevant boxes)

High Cholesterol of 7.5 or greater <input type="checkbox"/>	If so, which member of the family?	
Heart Attack <input type="checkbox"/>	If so, which member of your family? How old were they when they had the heart attack?	
Heart disease <input type="checkbox"/>	Stroke <input type="checkbox"/>	Cancer <input type="checkbox"/>
	Diabetes <input type="checkbox"/>	Hypertension <input type="checkbox"/>
		Asthma <input type="checkbox"/>
Other <input type="checkbox"/> (please specify)		

## DRUGS AND MEDICINES

(please tick relevant boxes)

Are you being prescribed medication on a repeat basis	<input type="checkbox"/> yes	<input type="checkbox"/> no
Are you allergic to any medications? <input type="checkbox"/> yes <input type="checkbox"/> no    If yes, please state .....		
.....		

## DISABILITY INFORMATION

(please tick relevant boxes)

Partially sighted <input type="checkbox"/>	Blind <input type="checkbox"/>	Hearing impaired <input type="checkbox"/>	Deaf <input type="checkbox"/>	Speech Defect <input type="checkbox"/>
Dyslexia <input type="checkbox"/>	Learning disability <input type="checkbox"/>	Mental Illness <input type="checkbox"/>	Mobility problem (please explain) <input type="checkbox"/>	

## LIFESTYLE

(please tick relevant boxes)

Do you smoke?	yes <input type="checkbox"/>	no <input type="checkbox"/>	If yes, number per day .....
If 'no' are you an ex-smoker?	yes <input type="checkbox"/>	no <input type="checkbox"/>	

How often do you have a drink that contains alcohol?	Never <input type="checkbox"/>	Monthly or less <input type="checkbox"/>	2-4 times per month <input type="checkbox"/>	2-3 times per week <input type="checkbox"/>	4+ times per week <input type="checkbox"/>
How many units of alcohol do you have on a typical day when you are drinking?	1-2 <input type="checkbox"/>	3-4 <input type="checkbox"/>	5-6 <input type="checkbox"/>	7-8 <input type="checkbox"/>	10+ <input type="checkbox"/>
How often do you have 6 or more standard drinks on one occasion?	Never <input type="checkbox"/>	Less than monthly <input type="checkbox"/>	Monthly <input type="checkbox"/>	Weekly <input type="checkbox"/>	Daily/almost daily <input type="checkbox"/>
<b>Scoring System</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
A total of 5+ indicates increasing or higher risk drinking. If you score 5+ we recommend that you make an appointment with one of our nursing team.					<b>Overall score =</b>

<b>Exercise</b>	Very active <input type="checkbox"/>	Moderate <input type="checkbox"/>	Gentle <input type="checkbox"/>	Inactive <input type="checkbox"/>
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<b>Diet</b>	Good <input type="checkbox"/>	Moderate <input type="checkbox"/>	Poor <input type="checkbox"/>	Vegetarian <input type="checkbox"/>	Vegan <input type="checkbox"/>
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## ABOUT YOU

(please tick relevant boxes)

Height .....	Weight .....
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Non-drug allergies (ie nuts, insect bites, pollen) .....			
Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Very Severe <input type="checkbox"/>

Do you take Aspirin regularly, which you buy over the counter? Yes  No

Have you had any of the following immunizations? Please give the date (year will suffice) and stage ie booster etc.

Tetanus <input type="checkbox"/>	date .....	stage .....
Combined Diphtheria/Tetanus <input type="checkbox"/>	date .....	stage .....
Polio	date .....	stage .....
Flu <input type="checkbox"/>	date .....	Pneumovax <input type="checkbox"/> date .....

## FOR WOMEN

Form of contraception used:

The Pill <input type="checkbox"/>	Coil (IUD) <input type="checkbox"/>	Condom <input type="checkbox"/>	Diaphragm (Cap) <input type="checkbox"/>
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