St James Surgery
New Patient Registration Form

Please complete this confidential questionnaire **in full**, if you do not complete the questionnaire in full, we will be unable to register you.

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.

<table>
<tr><td colspan="5">Full Name:</td><td colspan="3">Telephone Number:</td></tr>
<tr><td colspan="5">Mr / Mrs / Miss / Ms / Other.....</td><td colspan="3">Work Number</td></tr>
<tr><td colspan="5" rowspan="4">Address and Postcode</td><td colspan="3">Mobile Number:</td></tr>
<tr><td colspan="3">E-mail Address:</td></tr>
<tr><td colspan="3">Next of Kin/Relationship:</td></tr>
<tr><td colspan="3">Next of Kin Contact Number:</td></tr>
<tr><td colspan="3">Date of Birth:</td><td colspan="2">Previous / Mother's surname if different:</td><td colspan="3">Town & Country of Birth</td></tr>
<tr><td>Marital Status:</td><td></td><td>Gender:</td><td>Male:</td><td>Female:</td><td colspan="3" rowspan="3"></td></tr>
<tr><td colspan="5">Occupation:</td></tr>
<tr><td colspan="5">Names & Ages of Dependent Children (cont. on separate sheet if nec.)</td></tr>
<tr><td>Housing (Select one)</td><td>House</td><td>Maisonette</td><td>Flat</td><td>Mobile Home</td><td colspan="3">NHS Number (If Known)</td></tr>
<tr><td colspan="5" rowspan="2">Previous Address</td><td colspan="3">Previous Postcode:</td></tr>
<tr><td colspan="3">Previous Doctor Telephone No.</td></tr>
<tr><td colspan="5" rowspan="2">Previous Doctor Name & Address:</td><td>Previous data released?</td><td>Yes</td><td>No</td></tr>
<tr><td colspan="3">If applicable, date you first came to live in Britain:</td></tr>
<tr><td colspan="2">If returning from Armed Forces:</td><td colspan="3">Your Service or Personnel Number</td><td colspan="3">Your Enlistment Date</td></tr>
<tr><td>Your height:</td><td colspan="2">Feet / inches</td><td>cm</td><td>Your weight:</td><td>Stones / lbs.</td><td colspan="2">kg</td></tr>
</table>

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 1st language Spoken / Understood: (select one)	English	Hindi	Gujurati	Urdu	Bengali /Sytheti	Punjabi
Polish / Ukrainian	French	German	Spanish	Other: (Please Specify)		

Smoking, Alcohol Consumption and Exercise:

Are you currently a smoker?	Yes	No	Have you ever been a smoker?	Yes	No
If so, how many cigarettes / cigars / tobacco do you smoke in a week?			***If you are a smoker and want to stop, please ask for information about local smoking cessation services. Make an appointment to see the Practice Nurse to discuss quitting.***		
Go Smoke free:- www.nhs.uk/smokefree					

How often do you exercise?	No. times per week	Type(s) of exercise:	

How much alcohol do you drink in a week (Units)?
PLEASE COMPLETE THIS BOX - THANK YOU ➡ ☐
(One unit = 1 small glass of wine, a single measure of spirits, or 1/2 a pint of beer)

MEN: How often do you have EIGHT or more drinks on one occasion? WOMEN: How often do you have SIX or more drinks on one occasion?

Question	Score	Please tick which applies
Never	0 points	
Less than monthly	1 point	
Monthly	2 points	
Weekly	3 points	
Daily or almost daily	4 points	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?		
Never	0 points	
Less than monthly	1 point	
Monthly	2 points	
Weekly	3 points	
Daily or almost daily	4 points	
How often during the last year have you failed to do what was normally expected of you because of drinking?		
Never	0 points	
Less than monthly	1 point	
Monthly	2 points	
Weekly	3 points	
Daily or almost daily	4 points	
In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut		

down?		
N/A	0 points	
No	1 point	
Yes, on one occasion	2 points	
Yes, on more than one occasion	4 points	

Your Medical Background:				
What illnesses have you had & 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)				
Are you able to administer your own medicines?	**Yes**	**No – please detail specific issues (e.g. swallowing, opening containers)**		
Which Pharmacy would you like your medicine to go to (please circle): **Morrison's Rowlands Boots Other please specify _____**				
Women only:				
When was your last smear done?	**Date**	**Was this at your GP's Surgery?**	**Yes**	**NO**
What was the result of the smear?				
Date of last mammogram (if applicable):	**Date**	**Method of contraception (if used):**		
Do you wish to see a doctor in this practice for contraceptive services (including the pill, coil or cap)?			**Yes**	**NO**

Are there any serious diseases that affect your Parents, Brothers or Sisters (tick all that apply and state the family member affected)	**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:	
If you are a Carer, please state the name / address / phone number of the person you care for:	**Person Cared For Contact Details:**
If you have a Carer, 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:**

Sharing Relevant Information:

There may be occasions where we will need to share your information with other Health organisations (Hospitals, Referrals, health teams, social care, out of hours etc.) in order for you to receive the best care and service. There is a formal information sharing agreement in place with these organisations. To help us provide you with the best service only relevant information will be shared with the organisations below when necessary.

GP practices	Agree to Medical records to be transferred to new surgery	
Social Care Teams		
Provider Agencies	Carers/Domiciliary care/Physio	
Pharmacies	Sending your prescriptions	
Out of Hours Service	Calling 111	
Ambulance Service		
General hospitals and the departments within / Community Services	Including Neighbourhood Team (District Nursing Team) Referrals to hospitals / Urgent Admissions	
Care Homes, Hospices	Local Care Homes, Dorothy house	
Other organisations and/or members of your family or friends	please specify their details in the boxes below	

***Please specify and provide details of other organisations or family members you wish to share or are able to discuss your medical information with (*For individuals please include their date of birth & NHS Number):**

Please specify any exceptions:

- Do you consent to relevant information that the surgery record about you being accessible when necessary with other NHS/Social care services. **(Please circle) YES / NO**
- Do you consent to St James Surgery viewing information about you that has been recorded on your record by other service providers where you have received care? **YES / NO**
- When necessary do you consent to wounds being photographed and added to your medical records if deemed appropriate, for the purpose of treatment monitoring? **YES / NO**

I the Patient / Patients Representative (please circle) consent to relevant information being shared with the organisations and named individual/s indicated above

Print name: .....

Signature: .....

Do you have a "Living Will" (a statement explaining what medical treatment you would not want in the future)?	**Yes / No**	***If "Yes", can you please bring a written copy of it to your New Patient Consultation***
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:**

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 up to date with developments within the Practice.

Yes, I am interested in becoming involved in the Practice Patient Participation Group (Please tick the "Yes" Box)	**Yes**

Patient Signature:		**Signature on behalf of Patient:**	

Thank you for completing this form

For St James Surgery use only:-

ID Provided YES/NO _____(What form of ID)

Safety Check _____

Name of Staff member _____

Date _____