CORFTON ROAD SURGERY

NEW PATIENT REGISTRATION AND HEALTH QUESTIONNAIRE - ADULTS (16+)

Family Name: …….. First Name(s): ……

Home Tel. …… Work Tel. …… Mobile: ……..

Email address: ……..

Date of Birth: …….. Marital status: ……..

Ethnicity: ……..

Main language …….. Occupation: ……..

Weight: …… stones …… pounds **OR** ……kg. Height: ……ft……ins…… **OR** …….. metres.

Next of Kin: Name ……

Contact No ……

Relationship to Patient ……

CARERS
Do you look after someone who is frail, disabled or mentally ill? ☐ Yes ☐ No

If Yes;
Your relationship to the person you care for: ……
Please ask the receptionist about Carers support

SMOKING
☐ I have never smoked ☐ I am a pipe smoker

☐ I currently smoke ……. cigarettes/day ☐ I currently smoke …… ounces tobacco/week

☐ I am an ex-smoker. Date stopped …….. I used to smoke …….. per day.

ALCOHOL
Do you drink alcohol? ☐ Yes ☐ No

If Yes; how much do you drink per week?

Glasses of wine …… Pints of beer …… Measures of spirits …….

EXERCISE
Do you take regular exercise? ☐ Yes ☐ No

If yes, what sort of exercise? ……

How many times per week? ……..

FAMILY HISTORY
Has any member of your family (father, mother, brother, sister) ever suffered from?

Heart disease under 60 ☐ Yes ☐ No Which family member? …….

Heart disease over 60 ☐ Yes ☐ No Which family member? …….

Heart attack or stroke ☐ Yes ☐ No Which family member? …….

Hypertension (high blood pressure) ☐ Yes ☐ No Which family member? …….

Diabetes ☐ Yes ☐ No Which family member? …….

Asthma ☐ Yes ☐ No Which family member? …….

Cancer ☐ Yes ☐ No Which family member? …….

Type of cancer ……..

Any other family illnesses: ……..

ALLERGIES
Are you allergic to any medications, substances or foods? ☐ Yes ☐ No
If Yes; please give details:

……

CURRENT MEDICATION
Please give details of any medication which you are currently taking (prescribed or otherwise):

Name of drug: …… Name of drug: ……

Dosage: …….. Dosage: ……..

Name of drug: …… Name of drug: ……

Dosage: …….. Dosage: ……..

Name of drug: …… Name of drug: ……

Dosage: …….. Dosage: ……..

CURRENT MEDICAL HISTORY
Please give details of all current illnesses and conditions

……..

……..

……..

PAST MEDICAL HISTORY
Please give details of any hospital treatment as an in-patient:

……..

……..

Please give details of any treatment for any chronic medical conditions:

……..

FEMALE PATIENTS ONLY
Most recent cervical smear: Date …… Result ……

Where was smear taken: ☐ Other UK GP ☐ Private Clinic ☐ Abroad

NAMED GP
Every patient has a named GP. Your GP is **Dr Alex Fragoyannis.**
This does not affect your choice to see any other doctor at the surgery.

COMMUNICATIONS
Corfton Road Surgery would like to make sure that we give you information in a way that is clear to you.

When we write to you or contact you, please indicate which method you prefer?

☐ No preference ☐ Phone ☐ Email

Do you consent to receiving text messages? ☐ Yes ☐ No

Text messages will be used for

- Appointment reminders
- Flu or other vaccination clinics for targeted eligible populations
- Chronic disease review invitations
- Cervical screening
- Blood pressure and cholesterol monitoring
- Smoking status updates
- Requests to contact the practice to arrange appointments
- Confirmation of registration status
- Any communication that a clinician and patient have previously agreed may be texted

Please indicate if you have any specific communication requirements

☐ With Easy Read pictures and words

☐ By letter using large type

☐ When you come to the surgery do you need a British Sign Language interpreter?

☐ Other; please specify .....

If you need anything that is not on the list above, please tell our receptionist when you come in for your next appointment and we will do our best to meet your needs

ONLINE APPOINTMENTS

After you have been registered at the surgery, If you would like to book appointments online, please ask the receptionist for a Username and Password.

DATA PROTECTION

I understand that this information will be used exclusively in relation to my healthcare.

I agree that my medical information may be shared with other health organisations such as hospitals and walk in centres. ☐ Yes ☐ No

SIGNED ..... **DATE** .....