STOCKWELL GROUP PRACTICE – NEW PATIENT REGISTRATION FORM

Surname:	**First Name:**
Telephone - Mobile: **Home:** **Work:**	**Email:**
Next of Kin and relationship: ………………………………………………	 **Contact number of next of kin:………………………………………….**
Do you need an Interpreter? If yes what language?	

If you would NOT like to receive any communication by SMS text message please tick here ☐*	**If you would NOT like to receive any communication by email please tick here ☐***

***PLEASE BE AWARE THAT THIS WILL EXCLUDE YOU FROM APPOINTMENT REMINDERS**

Health Information:

Do you have any current medical conditions i.e. Diabetes, Asthma, Stroke, High blood pressure, HIV Positive, Dementia, Ischaemic Heart Disease, Learning Difficulties, Mental Health Problems, Other?

Condition:	**Current treatment / Medication:**

Allergies:

Medication	Food	Other

Smoking status: ***(please tick one box) Help to stop smoking is available call*** 0800 856 3409 or 020 3049 5791, email gst-tr.stopsmokinglambeth@nhs.net.

Do you smoke: ☐ cigarettes …… per day **☐ roll your own ……………….Grams per wk**	**☐Never smoked** **☐Ex smoker for …………years/months**	**Other forms of tobacco use state below**

Alcohol:

How often do you have a drink containing alcohol? *Please tick one box* ☐ *Never (1)* ☐ *Monthly or less (1)* ☐ *2-4 times a month (2)* ☐ *2-3 times a week (3)* ☐ *4+ times a week (4)*	
How many standard* drinks containing alcohol do you have on a typical day when you are drinking? ☐ *1-2 (0)* *3-4 (1)* ☐ *5-6 (2)* ☐ *7-9 (3)* ☐ *10+ (4)*	
How often do you have six or more standard* drinks on one occasion? ☐ *Never (0)* ☐ *Less than monthly (1)* ☐ *Monthly (2)* ☐ *Weekly (3)* ☐ *Daily or almost (4)*	
	Please use this box to record the total score (the numbers in brackets above) for the 3 questions
	How many units of alcohol, if any, do you drink in a typical week? If you are unsure then tell us what you drink below.*
******One unit/standard drink = ½ pint of ordinary beer/lager/cider or a single measure of spirits or a standard glass of wine, or a small glass of sherry/vermouth/aperitif*	

CARERS If you are you provide help for someone with a disability or illness or are reliant on help to live your daily life – please ask for our Carers Form.

I am a main carer [ ] **I have a carer [ ]**

Family History:

Condition	**Relative**	**Maternal \ Paternal**
Heart Disease (IHD) (under 60)		
Heart Disease (IHD) (over 60)		
Stroke		
Hypertension		
Diabetes Insulin or Non-Insulin		
Asthma		
Breast Cancer		
Cancer		
Other		

Cervical Smear:

Date taken	**At GP / Clinic in the UK**	**Result if Known**	**Recall Date if known**

HYSTERECTOMY: ☐ Yes ☐ No	If yes, date:

Screening: HIV TESTING:

All new patients registered at this practice are being offered an HIV test (please see attached).		
Would you like a HIV Test?	☐ *Yes* ☐ *No*	If yes, you will need to make an appointment to have a blood test at the surgery

Screening: CHLAMYDIA & GONORRHOEA SCREENING: *(for patients aged **under 25** years)*

Would you like a Chlamydia Test?	☐ *Yes* ☐ *No*	If yes, you will need to provide a specimen of urine

New Registration Health Check we offer all patients a basic health check with our health care assistant – height, weight ,BP etc (Please tick one box): Yes Please [ ] No Thanks [ ]

Ethnicity: *Please tick one box*

White	Asian or British Asian	Mixed Race	Black/Black British	Chinese or other ethnic Group
☐ *British* ☐ *Traveller* ☐ *Other White (please state*	☐ *Indian* ☐ *Pakistani* ☐ *Bangladeshi* ☐ *Other Asian (please State):*	☐ *White & Caribbean* ☐ *White & African* ☐ *White & Asian* ☐ *Other Mixed (please State):*	☐ *Caribbean* ☐ *African* ☐ *Other Black (Please state)*	☐ *Chinese* ☐ *Other Ethnicity (please state):*

What language do you prefer to read?		
I can read English	**Yes**	**No**
I was given help in completing this form as I do not read any language	**Yes**	**No**
Do you need large print?	**Yes**	**No**
Do you have a hearing problem	**Yes**	**No**
Do you rely on lip reading? [ ] text phone or minicom [ ] British Sign language [ ] Makaton [ ]		
What is your religion? Please state No Religion [ ]		

PLEASE LIST ALL THE NAMES OF THE PEOPLE WHO ARE LIVING IN THE SAME HOUSE AS YOU (Please continue on another page if necessary)

SURNAME	FORENAME	D.O.B.	RELATIONSHIP (i.e. mother, father, brother, sister etc)	UNDER 16'S, DOES THIS ADULT HAVE PARENTAL RESPONSIBILITY?

Summary Care Record

You have a choice of what information you share. Only Authorised healthcare staff can view your **SCR** with your permission. The information shared will be solely for the benefit of your care. Please indicate your choice below. More information is available on https://digital.nhs.uk/services/summary-care-records-scr or you can talk to your GP practice or call NHS Digital on 0300 303 5678

Express consent to share Medication, Allergies and Adverse Reactions only **[ ]** Read code **9Ndm**

Express consent to share Medication, Allergies and Adverse Reactions and **Additional Information** e.g. Illnesses and health problems, vaccination you have had **[ ]** Read code **9Ndn**

Express DISSENT (**OPT OUT**) – select this if you DO NOT want to share information with other healthcare professionals **[ ]** Read code **9Ndo**

Signed:…………………………………………………………………………………………………… **Date**:………………………………………………….

Staff Use only:
ID checked- (please tick) Birth certificate [ ] Passport [ ]

Other please state ……………………………………………………………………

Staff initials ………………… Date Rec……/………/……. entered on EMIS ……../……./……