KILLAMARSH MEDICAL PRACTICE – NEW PATIENT REGISTRATION

Name:

Marital status:

Previous Name (if applicable):

Address:

Post Code

Date of Birth:

Email Address:

Tel No:

Mobile No:

SMS Text Service:

We send out appointment reminders and information about other health campaigns by text message. If you do not have a mobile phone, we send this information out by an automated voice message to your land line.

This service is provided to patients over the age of 16 only.

You may **OPT OUT** of the service by ticking this box ☐

Do you suffer from any other significant illness?
If yes, please give details

Do you have any allergies?
If yes, please give details

Do you have any communication/information needs relating to disability, impairment or sensory loss?

If so, please state:

Do you have any preferred communication needs:

Braille ☐ Audio ☐ Large print ☐ Interpreter ☐

Other (please state):

List of Medication:

Ethnicity and Main Spoken Language:

We are required to ask you to provide details of your ethnic origin for statistical purposes. Please tick one box below.

- ☐ British or mixed British
- ☐ Irish
- ☐ Caribbean
- ☐ African
- ☐ Indian or British Indian
- ☐ Pakistani or British Pakistani
- ☐ Bangladeshi or British Bangladeshi
- ☐ Chinese
- ☐ White and Asian
- ☐ Other Asian background
- ☐ Other black background
- ☐ Other mixed background
- ☐ Other

We are required to ask you to provide details of your main spoken language for statistical purposes. Please tick one box.

☐ English ☐ Other (please specify) _____

Are you a carer for a family member or friend? ☐

MEDICAL HISTORY *(Please tick Yes or No)*

	Yes	*No*
Do you consider yourself to be fit and well?	☐	☐
Have you ever suffered from:		
♦ Stroke	☐	☐
♦ Heart Attack	☐	☐
♦ Angina	☐	☐
♦ High Blood Pressure	☐	☐
♦ Diabetes	☐	☐
♦ Asthma	☐	☐
♦ Epilepsy	☐	☐

LIFESTYLE:

Height: ☐ Weight: ☐

Smoking Data:

Please provide details of your smoking history so we can add this to your medical record. Thank you.

Never smoked (✔) ☐

Ex-smoker (✔) ☐ Year stopped ☐

Quantity per day ☐

Current smoker(✔) ☐ Quantity per day ☐

	Yes	*No*
Would you like any support to help you to quit?	☐	☐

Alcohol Data:

Please provide details of your alcohol consumption in units per week so we can add this to your medical record. Thank you.

Average quantity in units per week: ☐

Exercise / Diet:

	Yes	*No*
Do you exercise?	☐	☐
Would you like any exercise or diet advice?	☐	☐

ONLINE ACCESS

We automatically enrol patients for online access services at initial registration. Online access enables you to make appointments and order repeat prescriptions at any point of a day.

Please tick here to Opt out : (✔) ☐

Access to your medical records online is also available; please ask reception for the medical online request form.

SIGNATURE:	**PRINT NAME:**	**DATE:**

PLEASE MAKE A NEW PATIENT HEALTH CHECK APPOINTMENT WHEN YOU HAND THIS FORM IN

06/11/17