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 ☐

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	☐	☐

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 below:

List of Medication:

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

For online access to make appointments, order repeat prescriptions or have access to your medical records, please ask Reception when you are next in the surgery.

Please remember to provide proof of identity.

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

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

23/09/16