Health check appt made	
Date:	Initial:

Dr Shantir Practice

REGISTRATION QUESTIONNAIRE

ID Checked	
Form Checked	

Have you been previously registered with this practice? Yes ☐ No☐							
Title*		**First Name***		**Last Name***			
D.O.B*		**NHS Number**			**Gender**	Male ☐ Female☐	
Home Address*				**Contact Numbers***	Home:		
					Work:		
					Mobile:		
Email Address							
Country/Place of Birth*			**Country of Origin***				
What is your main language*			**Do you need an Interpreter***	Yes ☐ No ☐			
Next of kin*		**Relationship***					
Contact Number*		**Can Discuss Medical Record***	Yes ☐ No ☐				
Marital Status	Single	Married	Divorced	Civil Partner	Widowed	Other (please State)	
If you are aged 15 or under, please give a name and relationship of who looks after you Name: Relationship: Mobile:							

If you are over 40 you will be required to book an appointment with our Health Care Assistant/Practice nurse to book an appointment

The NHS Shared Business Service requires us for the following information, this is optional								
Religion	None ☐	Buddhist ☐	Christian ☐	Hindu ☐	Jewish ☐	Muslim ☐	Sikh ☐	Other (please State)
Ethnicity	White	Mixed		Asian/British Asian		Black/Black British	Other	Not Stated
	British ☐	White & Black African ☐		Bangladeshi ☐		Caribbean ☐	Chinese ☐	
	Irish ☐	White & Black Caribbean ☐		Indian ☐		African ☐	Any Other ☐	
	Other ☐	White & Asian ☐		Pakistani ☐		Other Black ☐		
		Other mixed ☐		Other Asian ☐				

Do you have a disability/special requirement that we need to take into account? Yes ☐ No ☐			
If yes, please give details:			
Are you a carer? (Do you look after a friend or relative who is sick, disabled, elderly, who has mental health problems or for any other reason) Yes ☐ No ☐			
Do you have a carer? Yes ☐ No ☐			
Carers name		**Telephone number**	Yes ☐ No ☐
Next of Kin		**Can discuss medical record**	Yes ☐ No ☐

Medical Condition/Lifestyle			
Are you attending a hospital at present? Yes ☐ No☐	Reason		
Name/address of hospital		Hospital number	On a waiting list
			Yes ☐ No ☐

Medical Condition/lifestyle continued					
Allergies*					
Current Medications					
Occupation					
Weight		**Height**		**Max recorded non-pregnant weight**	

Smoking*	Do you currently smoke	Yes ☐ No ☐	Per day		Year started	
	Would you like help/advice on stopping? Yes ☐ No ☐ Call the surgery to book an appointment on Wednesday afternoons					
	Are you an Ex- Smoker	Yes ☐ No ☐	Per day		Year Stopped	

Alcohol*	How often do you have an alcoholic drink?				
	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
	How many standard drinks containing alcohol do you have on a typical day when you are drinking?				
	1 or 2	3 or 4	5 or 6	7 or 9	10 or more
	How often do you have 6 or more standard drinks on one occasion?				
	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
	Current Drinker ☐ Current weekly consumption _____units per week				
Exercise*	How often do you exercise?				
	0 times/week	1 times/week	2 times/week	3+ times/week	
	Any Comments				

Medical History Have you had any of the following					
Condition	**Year Diagnosed**	**Condition**			**Year Diagnosed**
Alzheimer's Disease		Arthritis			
Asthma		Cancer (please specify type)			
Chronic Obstructive Pulmonary Disease		Depression			
Diabetes (please state type ½)		Skin Condition			
Heart Disease under 60		Heart Disease over 60			
High Blood Pressure		High Cholesterol/lipids			
Hypothyroidism		Psychological Problems			
Stroke		Multiple Sclerosis			
Chronic Kidney Disease		Epilepsy	Last seizure?	How often?	
Any other conditions (please specify)					
		Do you attend hospital for the condition?			

Past Operations			
Operation	Year	Procedure	Hospital

Family History Has a member of your family (blood related) had any of the following			
Condition	**Family Member**	**Condition**	**Family Member**
Arthritis		Asthma	
Eczema		Diabetes(type ½)	
High Blood Pressure		Stroke	
Chronic Obstructive Pulmonary Disease		Heart Disease over 60	
Heart Disease under 60		Hypothyroidism	
High cholesterol/ Lipids		Epilepsy	
Cancer(state type)		Multiple Sclerosis	
Chronic Kidney Disease (stage if known)		Alzheimer's Disease	
Any other condition (please specify)			

MALE PATIENTS PLEASE GO TO LAST PAGE

Female Patients ONLY											
Age at first period		**Cycles regular?**	Yes ☐ No ☐		**Age at Menopause**						
Any Menstrual problems?											
Any family history of breast or ovarian cancer?	Yes ☐ No ☐	**Relation**		**Specify which one**							
Pregnancies	Year	Outcome (male/female/still/live)		Place							
Family Planning											
None	☐	Sheaths	☐	Natural Methods	☐	Coil	☐	Diaphragm/cap	☐		
Pill	☐	Injections	☐	Progesterone only pill (mini pill)	☐	Female sterilisation	☐	Male sterilisation	☐		
Smears											
We advise patients to have a cervical smear every three years which is carried out by the Practice Nurse. A smear test appointment should be booked 10-14 days after the period has stopped. Intercourse should be avoided for 2 days before the test.											
Have you ever had a smear test?	Yes ☐ No ☐	When and where did you last have a smear test									
Have you ever had an abnormal result?	Yes ☐ No ☐	If yes please give the date									
Would you like an appointment for a smear test?	Yes ☐ No ☐										

PLEASE GO TO THE NEXT PAGE TO COMPLETE THE REGISTRATION FORM AND HAND IN AT RECEPTION. PLEASE NOTE, REGISTRATION TAKES 48HRS HOWEVER IT CAN TAKE UP TO 6 DAYS.

Patient Access	
If you would like to order medications, book appointments and view areas of your medical record online. Sign up for a Patient Access Pin to use once you are registered with this practice. A pin will be generated, you will be notified when this is ready by email or text and you will have 2 weeks to activate it.	
I would like a Patient Access Pin	Yes ☐ No ☐

Electronic Prescribing			
Please nominate a pharmacy that you would like future prescriptions to be sent to electronically			
Name of Pharmacy		**Pharmacy Address**	

Summary Care Record	
Summary Care Record is a summary of your medications, adverse reactions and allergies. This summary is uploaded to the NHS Spine which is a secure database and is only accessed, with your consent, by medical staff in the event of an emergency for example, attended A&E, walk in clinic or called the out of hours service.	
I am happy for my record to be uploaded ☐	**I wish to opt out of this service ☐**
Care.data National Scheme	
Care.data aims to make increased use of information from medical records with intention of improving healthcare via research; public health use and commissioning. There is 2 levels of opting out of this service.	
1. I do not want my data to leave the health and social care information centre ☐	**2. I do not want my data to leave the GP Practice☐**

Patient Participation Group
Being a part of the PPG you will help; improve on the experience of attending the surgery, the practice decisions on overall service priorities, bring to the attention a patients perception of the practice plus much more. If you become a member of this group you will be contacted by email by the chairperson of the group. More information is available in reception about this group.
I would like to be a part of the patient participation group and I am happy for my email to be passed on to the chairperson of the group for future contact ☐

Disclosure:

I the patient named below, agree to disclose all material facts regarding my health to my General Practitioner and his/her clinical staff.

Appointments:

I agree to attend on time for all appointments that I book with the practice and to cancel, in advance, any appointment that I cannot attend. I acknowledge that should I arrive late for an appointment I may be asked to rebook for another time. I understand that should I not attend my appointment (DNA) more than 3 times a warning will be issued and if continued may be struck off the GP list.

Prescriptions:

I understand that when requesting repeat prescriptions that I need to give the Practice 2 working days notice of my request.

Treatment of staff:

I agree with the **ZERO TOLERANCE** policy of abuse towards all NHS staff and I agree **NOT** to behave in an abusive, threatening or otherwise aggressive manner with any member of the practice staff.

I acknowledge the right of the practice to remove me from their list without appeal, should I behave in a prohibited manner

Name		**Date**	
Sign		**Signing on behalf of**	