****

**Dr Keir Newsom The Glebe Surgery**

**Dr Gillian Lewis Monastery Lane**

**Dr Marco Cecchini Storrington**

**Dr David Sherwell Pulborough**

**Dr Jenny Ellis West Sussex**

**Dr Laura Wollaston RH20 4 LR**

**Dr Amy Garrett**

Tel. No.01903 742942 Fax No. 01903 740700

**REGISTRATION QUESTIONNAIRE**

**Please answer these questions as best you can. Precise dates are not too important. Just tick the relevant boxes where possible.**

**Surname................……… Christian Name(s).......................................known as...............**

**Date of Birth .....................Tel. No..................................Mobile Tel. No. ……………………**

**Next of Kin …………………………………(Relationship) Tel. No. …………………………**

**Opt out of SMS text service Yes / No 9Ndq-No 9Ndp-Yes**

**Opt in to Electronic Prescriptions Yes / No**

**Nominated Pharmacy………………………………………………………………………………….**

**You will also need to provide the following forms of ID to complete your registration**

**1 . NHS Number**

**2 . Proof of current UK address** ( one of the following **)**

Full UK driving licence

Recent utility bill ( less than 3 months old 0)

Bank statement ( less than 3 months old 0 – a copy will be taken omitting your account details and the original returned to you

Council Tax Bill , payment book or exemption certificate ( less than 12 months old )

Council / Housing Association tenancy agreement . Private tenancy agreements are not accepted

Council rent book/card ( showing payment within the last 12 months )

**Ethnic Origin ( Please tick as appropriate )**

British ­\_\_\_\_\_ Irish \_\_\_\_\_\_ Other White \_\_\_\_\_

**Black or British** Africa \_\_\_\_\_\_ Caribbean \_\_\_\_\_ Other Black \_\_\_\_\_

**Asian or Asian British** Bangladeshi \_\_\_\_ India \_\_\_\_\_ Pakistani \_\_\_\_\_

**Mixed Parentage** White & Black Caribbean \_\_\_\_\_\_ White & Black African \_\_\_\_\_

 White & Asian \_\_\_\_\_\_ Other Mixed \_\_\_\_\_\_

 Chinese \_\_\_\_\_ Other ethnic Group \_\_\_\_ Prefer not to say \_\_\_\_

**Are you a carer? YES / NO (A receptionist will be able to advise you of services available for carers).**

**Do you have any information or communication needs.**

**Hearing, Sight, Language etc. Please state clearly**

**…………………………………………………………………………………………………………..**

**…………………………………………………………………………………………………………..**

**…………………………………………………………………………………………………………..**

**(Admin note. Please add patient alert for any communication needs detailed above)**

**Consent for contact about new services Yes / No (9Nds & 9Ndy)**

**If you wish to withdraw consent for new services please contact the Practice Manager (9Nde)**

**Past Medical History - List major illnesses and operations.**

**Date Date**

|  |  |  |  |
| --- | --- | --- | --- |
| **e.g.** | **Had appendix out** |  |  |
|  |  |  |  |
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###### Family Medical History

|  |  |  |
| --- | --- | --- |
|  | **Alive and well** | **List any major medical problems e.g. heart disease, blood pressure, cancer, diabetes etc.** |
| **Father** |  |  |
| **Mother** |  |  |
| **Brothers** |  |  |
|  |  |  |
|  |  |  |
| **Sisters** |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

## Drugs

**Name of Drug Strength How many per day**

|  |  |  |
| --- | --- | --- |
| **e.g. Inderal** | **40 mg** | **3 Tablets daily** |
|  |  |  |
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**Drug Allergies**

**Name Reaction**

|  |  |
| --- | --- |
| **e.g. Penicillin** | **Rash** |
|  |  |
|  |  |
|  |  |

#### Physical Examination

**Weight .……. .st ………… lbs. or …………… kg**

**Height ……… ft ……. inches or …………….metres**

**Waist Circumference ………….**

## Females over 20 Years old

**Cervical Smears Have you had a smear test? YES / NO**

**Date of last test …………..**

**Mammogram Have you ever had a mammogram (breast X-ray)? YES / NO**

**Date of Mammogram …………………..**

**Social History**

|  |  |  |  |
| --- | --- | --- | --- |
| **Married**  | **Single**  | **Divorced**  | **Widowed**  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Smoking Habit** | **Non-smoker** | **Smoker** | **How many?** |

**Alcohol use can affect your health and can interfere with certain medications and treatments. It is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest.**

Please tick the answer that is correct for you:

**1 unit of alcohol is approx. ½ pint average strength beer/lager or 1 small glass of wine or 1 single measure of sprit**

|  |
| --- |
| How often do you have a drink containing alcohol? |
| Never  | Monthly or less  | 2 - 4 times a month  | 2 - 3 times a week  | 4 or more times a week  |
| How many units of alcohol do you have on a typical day when you are drinking? |
| 1 or 2  | 3 or 4 |  | 5 or 6  | 7 to 9  | 10 or more  |
| How often do you have 6 or more units on one occasion? |
| Never  | Monthly or less |  | monthly  | weekly  | Daily or almost daily  |
| How often during the last year have you found that you were **not** able to stop drinking once you had started? |
| Never  | Monthly or less |  | monthly  | weekly  | Daily or almost daily  |
| How often during the last year have you failed to do what was normally expected of you because of your drinking? |
| Never  | Monthly or less |  | monthly  | weekly  | Daily or almost daily  |

**Alcohol can be detrimental to your health; we can provide help to those whose drinking poses a health risk. Please book an appointment with a GP if you would like to discuss this further**.

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**Thank you for your help with completing this questionnaire**