Dr Keir Newsom
Dr Marco Cecchini
Dr David Sherwell
Dr Jenny Ellis
Dr Charlie Woodhams
Dr Laura Wollaston
Dr Amy Garrett
Dr Sarah Donswijk

The Glebe Surgery
The Glebe
Storrington
Pulborough
West Sussex
RH20 4FR

Tel. No. 01903 742942

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. ……

Email address …….

Opt in to SMS text service **Yes / No**
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)

White	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 ____

Please bring I.D. with you (Proof of name and a U.K. Address)

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

Are you a Military Veteran YES/NO

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
If you wish to withdraw consent for new services please contact the Practice Manager

Past Medical History - List major illnesses and operations.

Date		Date	
e.g.	Had appendix out		

Family Medical History

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

Please bring I.D. with you (Proof of name and a U.K. Address)

Drugs

Name of Drug	Strength	How many per day
e.g. Inderal	*40 mg*	*3 Tablets daily*

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?

Please bring I.D. with you (Proof of name and a U.K. Address)

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 spirit

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

Please bring I.D. with you (Proof of name and a U.K. Address)