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| **Dr Keir Newsom****Dr Marco Cecchini****Dr David Sherwell** **Dr Jenny Ellis****Dr Laura Wollaston****Dr Charlie Woodhams****Dr Amy Garrett****Dr Sarah Donswijk****Dr Faye Mcwilliam** |  |  **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.**

**First Name………………………………… Surname................……………………..**

**known as...............................................**

**Date of Birth.............................................**

**Tel. No................................................. Mobile Tel. No.……………………………………**

**\*Please note if you provide us with a mobile telephone number\***

**We will use it to send you health related messages as these are permitted and not considered to be direct marketing. This includes appointment reminders,clinic.opening hours, new gp,health updates,**

**If you wish to opt your mobile out of receiving communications from us please let us know.**

**Email address ……………………..………………………………….**

**Next of Kin…………………….………… Relationship……………….……….……………**

**Tel. 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**

**\* If you have not already registered/Submitted ID on the NHS App\***

* NHS Number
* Proof of current UK address(one of the following)
	+ Full UK driving licence
	+ Recent utility bill (less than 3 months old)
	+ Bank statement (less than 3 months old) – 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)

**Are you a Carer?**

A Carer is anyone, including children and adults who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, mental health problem or addiction and cannot cope without their support.

**YES/NO**

If your answer is yes, please give the name and relationship to you of the person you are caring for and we will send out a carers registration pack to you:

Name of person cared for ..............................................................................................

and relationship to you   ………………………………………………………………………

**Are you a Military Veteran YES/NO**

If you have ticked YES. Do you have any support requirements because of this?

……………………………………………………………………………………………………

**Do you have any information or communication needs? E.g. Hearing, sight, language etc. Please state clearly:**

**……………………………………………………………………………………………………**

**……………………………………………………………………………………………………**

**……………………………………………………………………………………………………**

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

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

|  |  |  |  |
| --- | --- | --- | --- |
| **e.g. 01.01.2000** | **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 ………….**

**Social History**

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

**Smoking Habit**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Never Smoked** | **Ex smoker** | **Smoker** | **How many ?** | **Vaper**  |

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 approximately ½ pint of 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  | Less than monthly |  | 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**.

***Version 1. 17 April 2023***