Albany House Surgery

# Patient registration and health questionnaire (Adult 16 & over)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Title: (Mr, Mrs, etc.)** |  | | **Date of birth** |  |
| **Place of Birth** |  | | | |
| **Forename(s)** |  | | | |
| **Surname** |  | | **Previous surname** |  |
| **Calling name** |  | | **Occupation** |  |
| **Current address** |  | | | |
| **Home phone number** |  | | **Mobile phone number** |  |
| **Email address** |  | | | |
| **NHS number** | |  | | |
| **Previous address** | |  | | |
| **Previous GP** | |  | | |
| **Have you been registered here previously? If yes, please give dates.** | |  | | |
| **Have you moved to the UK from abroad? If yes, give date of arrival in the UK.** | |  | | |
| **Next of kin details:**  **Title:**  **Surname:**  **Forename:**  **Relationship:**  **Address:**  **Telephone numbers:** | |  | | |
| **Armed Forces veterans’**  **service:**  **Dates of service:**  **Discharge date:**  **Address prior to serving:** | |  | | |
| **Special circumstances:** | | Please tick if any of the following apply:  I have a carer  I am a carer  Asylum seeker  Housebound  Live in a nursing home  Live in a residential home  Live in a community psychiatric home  Live in a children’s home | | |
| **Height** |  | | **Weight** |  |
| **Allergies** |  | | **Disabilities** |  |
| **Are you:**  **Registered blind or partially sighted**  **Registered deaf**  **Registered disabled** | | | Please state which of these apply: | |
| **Please state your ethnicity** | | |  | |
| **Do you have any drug allergies?**  ***Please include known reactions*** | | |  | |
| **Do you have any other allergies?**  ***Please give as much detail as possible*** | | |  | |
| **Do you suffer from any of the following:**  **Heart disease**  **Hypertension**  **Asthma**  **Diabetes**  **COPD**  **Chronic kidney disease**  **Epilepsy**  **Stroke**  **Cancer** | | | Please state which of these apply and give date of last review: | |
| **Do you have any other serious or chronic illness?** | | | Please explain: | |
| **Do you have a family history of:**  **Diabetes**  **Heart disease**  **High cholesterol**  **Heart attack**  **Stroke**  **Cancer** | | | Please give details including relationship, illness and age at diagnosis if known: | |
| **Have you had any significant injuries or major operations?** | | | If yes, please give details: | |
| **Smoking status – Are you:**  **A current smoker**  **An ex-smoker**  **A non-smoker** | | | If a current or ex-smoker, please give details of how many you smoke or smoked per day. If you are an ex-smoker please give the date you stopped (month/year). | |
|  | | |  | |
| **How many units of alcohol do you drink on a typical day when you are drinking? (1 unit = ½ a pint or a small glass of wine or a single pub measure of spirits)** | | | Please tick which applies:  1-2  3-4  5-6  7-9  10+ | |
| **How often have you drunk more than 8 units (men) or 6 units (women) on a single occasion in the past year?** | | | Please tick which applies:  Never  Daily  Weekly  Monthly  Less often than monthly | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Alcohol scoring system** | 0 | | 1 | 2 | | 3 | 4 | | Score |
| **How often do you drink alcohol** | Never | | Monthly or less | 2-4 times per month | | 2-3 times per week | 4+ times per week | |  |
| **How many units of alcohol do you drink on a typical day when drinking?** | 1-2 | | 3-4 | 5-6 | | 7-9 | 10+ | |  |
| **How often have you drunk more than 8 units (men) or 6 units (women) on a single occasion in the past year?** | Never | | Less often than monthly | Monthly | | Weekly | Daily or almost daily | |  |
| **Current medication** | | If possible, attach a copy of your repeat prescription list. | | | | | | | |
| **Medication** | | Dosage | | | Repeat | | | Quantity remaining | |
|  | |  | | |  | | |  | |
|  | |  | | |  | | |  | |
|  | |  | | |  | | |  | |
|  | |  | | |  | | |  | |
|  | |  | | |  | | |  | |

|  |  |
| --- | --- |
| **Females only:** | |
| **Date of last cervical smear** |  |
| **Contraception used** |  |
| **Over 65s:** | |
| **Have you had a pneumonia vaccine in the last 10 years?** |  |
| **Have you had a flu vaccine this year?** |  |
| **PATIENT DECLARATION** | |
| **I confirm that, to the best of my knowledge, the information I have provided is accurate and correct.** | |
| **Signature** |  |
| **Print name** |  |
| **Date** |  |

Thank you for completing this form.