DENMARK STREET SURGERY

NEW PATIENT REGISTRATION FORM
(Under 16 years)

Please complete this questionnaire when registering with the Practice or whilst waiting to see the Doctor or Nurse. It will assist us with looking after your health.

PERSONAL DETAILS

Surname		First Name	
Middle Name		Male/Female	
Date of Birth			
Previous Surname			
Address			
Postcode		Home Telephone	
Mobile Number			
		Country of Birth	
Ethnicity (see attached list)		Religion:	

INFORMATION REGARDING YOUR HEALTH

Height		Weight	
Smoking Status	YES/NO	How many?	
Ex-smoker	YES/NO	How many and date stopped?	
Alcohol Status	YES/NO	How much per week? (glasses)	
Type of alcohol	Beer/Wine/Spirits		
Regular Exercise	YES/NO	How may times per week? (20 mins or more)	
Serious illness/operation	YES/NO	Details:	

COMMUNICATING WITH OUR PATIENTS

We want to get better at communicating with our patients. We want to make sure you can read and understand the information we send you. If you find it hard to read our letters or if you need someone to support you at appointments, please let us know.
We want to know if you need information in braille, large print or easy read.
We want to know if you need a British Sign Language interpreter or advocate.
We want to know if we can support you to lip read or use a hearing aid or communication tool.
Please inform the receptionist when you register with the Practice or state below.
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FOR FEMALE PATIENTS ONLY

Do you use contraception	YES/NO	Type:

Have **you** ever suffered from any of the following problems?

Medical Condition	**YES/NO**	**DETAILS (date of diagnosis, treatment etc)**
Diabetes		
Asthma		
Heart disease, MI or CVA stroke		
Epilepsy		
DVT		
Pneumonia		
Bronchilitis		
Poor mental health		

MEDICATION (please fill in with details of your current medication)

Name	**Dose**	**Frequency**	**Condition**

VACCINATIONS:

Vaccination	**YES/NO**	**Date Given**	**Vaccination**	**YES/NO**	**Date Given**
BCG			Meningitis C		
Tetanus			Pertussis		
HIB			MMR		
Hepatitis A			Hepatitis B		
Diphtheria			Polio		
Typhoid			Yellow Fever		
Any other:					

FAMILY HISTORY:

Have any close relatives (mother, father, brother, sister) ever suffered from any of the following? (If **yes**, please indicate which family member)

Medical Problem	**YES/NO**	**RELATIVE**
Any form of cancer (please state type):	YES / NO	
Thyroid disorder	YES / NO	
Diabetes	YES / NO	
Osteoporosis	YES / NO	
Cholesterol problems	YES / NO	
Gout	YES / NO	
Asthma	YES / NO	
Mental illness (e.g. dementia, depression, alcoholism, suicide, schizophrenia)	YES / NO	
Heart attack, stroke, cardiac problems	YES / NO	

Please complete and return to the GP receptionist who will forward the form to your Child Health Records Department

Date: ……..Parent/Legal Guardian Name…….Relationship to Child/Children……

Present Address: ……

Previous Address: ……..

Name & Address & Contact number of previou GP: ……..

Name	1st Child	2nd Child	3rd Child	4th Child
First Name of Child				
Surname of Child				
Date of Birth				
Male/Female				
NHS No.				
Previous Nursery/School				
Nursery/School Attending Now				
Name & Contact details of Previous GP				

For use by the GP practice. Fax this completed form to a safe haven fax No. 0191 3876563 and put form in HV box