**Dukinfield Medical Practice**

Dr T Dowling, Dr J Harvey, Dr E Roberts, Dr H McBride, Mr B Parsons

|  |  |
| --- | --- |
| **Concord Way Site:**20-22 Concord WayDukinfield, Cheshire, SK16 4DBTelephone 0161 343 6382 | **Birch Lane Site:**83 Birch LaneDukinfield, Cheshire. SK16 4AJTelephone 0161 330 2039 |

# *New Patient Registration Form*

Please complete this confidential questionnaire (one for each member of the family to be registered with the Practice).

Please complete in BLOCK CAPITALS and tick the boxes as appropriate.

***Please bring identification and proof of address.***

|  |  |
| --- | --- |
| **Mr / Mrs / Miss / Ms / Other……..**  | **NHS Number:**  |
| **Full Name:** | **Daytime Telephone Number:****Mobile Number:** |
| **Date Of Birth:** |
| **Address and Postcode:****Previous address :** | **E-mail Address:** |
|  **Town & Country of Birth:** |
| **If born outside the UK, date you entered the country:** |
| **Next of Kin:****Relationship to you:** |
| **Previous/Maiden name if different** | **Next Of Kin Address & Contact Number:** |
| **Previous GP:****Previous GP Address:** | **Are you a Carer?**  | **Yes / No** |
| **If yes please provide details:** |
| **Are you cared for?**  | **Yes/No** |
| **If yes please provide details:** |
| **If returning from** **Armed Forces:** | **Your Service or Personnel Number** | **Your Enlistment Date** |
| **Are you an Armed Forces veteran?** | **YES / NO Any further information you would like to give:** |
| **Your****height:** | **Feet / inches** | **cm** | **Your****weight:** | **Stones / lbs.** | **kg** |
|  |
| **Your religion:** |  | **Your main or 1st spoken language:** |  |
| **Your Ethnic Origin:** |  | **Do you require an interpreter/translator?** | **Yes/No**  |
|  |
| 1. **Which of your following options best describes how you think of yourself?**

Woman (including trans woman)Man (including trans man)Non-binaryIn another way (please state) …………………………………..1. **Is your gender identity the same as the gender you were given at birth?**

YesNo1. **Which of the following options best describes how you think of yourself?**

Lesbian Bisexual GayHeterosexual/Straight In another way (please state) …………………………………… |
|  |
| **All patients will now be allocated to Dr Dowling as their named accountable GP.** **Please note that you can see any GP within the practice.****Your Medical Background:** |
| **What illnesses have you had & When?** |  |
| **What operations have you had and When?** |  |
| **Do you have any medical problems at present?** |  |
| **Please list any tablets, medicines or other treatments you are currently taking:****(incl. dose + frequency)****Medication****continued** |  |
| **Pharmacy you wish to be nominated to**  |  |
| **Are there any** **serious diseases that affect your Parents, Brothers or Sisters** **(tick all that apply)** | **Diabetes** | **Heart Attack** | **Heart attack under age of 60** | **Bowel Cancer** |
| **Breast Cancer** | **High Blood Pressure** | **Asthma** | **Stroke** |
| **Thyroid Disorder** | **Any other important Family Illness?** |
|  |
| **Do you have any allergies?** |  |  | **Yes/No** |  | **Details:** |  |  |  |
| **Are you allergic to any medication?** |  |  | **Yes/No** |  | **Details:** |  |  |  |
| **Are you House Bound?**Office use:13ca |  |  | **Yes/No** |  |  |  |  |  |
| **Do you need information in a different form?** |  |  | **Yes/No** |  | **If yes, which of the following?** | **Braille** |  | **Large Print** |  | **Audio** |  | **Other:** |
| **Children ONLY** |
| **What immunisations have you had? (please tick all that apply)** | **Measles** | **German** **Measles** | **Diphtheria** | **Tetanus** | **Polio** | **MMR** |
| **Whooping Cough** | **Pre-school booster** | **Triple vaccine (Diphtheria,****Tetanus & Pertussis) –****3 doses** |
| **Women only:** |
| **When was your last smear done?** | **Date** | **Was this at your****GP’s Surgery?** | **Yes** | **NO** |
| **What was the result** **Of the smear?** |  |
| **Date of last mammogram****(if applicable):** | **Date** | **Method of contraception (if used):** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient****Signature:** |  | **Signature on****behalf of Patient:** |  |

|  |
| --- |
| The practice wishes to expand its methods of communicating with patients to include the use of email and text messaging. Patient Privacy is important to us, and we would like to communicate with you regarding any activities that may be of interest, which means that we need your consent. This may include using text/emails to provide updates on new developments at the practice, quarterly newsletters, invitations to community health events.*Emails and text messages are generated using a secure facility, but because they are transmitted over a public network they may not be secure. Email and text communication will never be used for urgent communications. Your contact details will be used solely in relation to healthcare services offered by the practice, and you can choose to opt out of the services at any time by contacting the practice.* |
| **If you wish to receive emails please sign here** |  |
| **If you wish to receive text messages please sign here** (please note this does not relate to appointment confirmation and reminders) |  |

|  |
| --- |
| **Office use only:****New Patient Check booked? Yes No Date Booked :**  |
| **When you have taken this form from the patient please fill out the following and state what identification it is that you have seen:** ***Photo ID:******Proof of address:*** ***Staff Name and Signature:*** ***Date:*** ***Date registered:*** |

**SMOKING ADVICE**

According to new Government guidelines we are now required to hold a record of the smoking habits of all our patients once they reach the age of 14.

For anyone, who has ever smoked it is required that this information is re-recorded annually.

We are also required to record that we have advised each of our patients about the health hazards of smoking. These include an increased risk of:

* Lung Cancer
* Coronary Heart Disease
* Peripheral vascular disease
* Chronic Obstructive Pulmonary Disease (which includes chronic bronchitis and emphysema)
* Cervical Cancer
* Mouth and throat cancer
* Difficulty conceiving (men and women)
* Miscarriage
* Low birth weight babies
* Chest problems in the children of smokers

**If you require further information about our Help to Quit Programme please contact the Surgery on 0161 3436382**

|  |  |
| --- | --- |
| Do you smoke?  | Yes / No  |
| If Yes, How many per day? ……………………………………… | If YES, would you like help to stop smoking? Yes / No |
| Ex-Smoker?  | Yes/No Date: |
| E Cigarette Smoker  | Yes/No |

|  |
| --- |
| **ALCOHOL INTAKE** *please circle each answer (health worker will score it)* |
| **Questions** | **Scoring System** |   |
| **0** | **1** | **2** | **3** | **4** | **Your Score** |
| How often do you have 8 or more units on one occasion in the last year? | **never** | **less than monthly** | **monthly** | **weekly** | **daily or most days** |   |
| How often in the last year have you failed to do what is normally expected of you because you have been drinking? | **never** | **less than monthly** | **monthly** | **weekly** | **daily or most days** |   |
| How often in the last year have you not been able to remember what happened when drinking the night before? | **never** | **less than monthly** | **monthly** | **weekly** | **daily or most days** |   |
| Has a friend, relative, doctor, or other health worker been concerned about your drinking or suggested you cut down? | **No** |  | **Yes, but not in the last year** |  | **yes, during the last year** |   |
|  | **TOTAL** |  |
|  |  | http://www.staffordshirecares.info/pages/images/food-and-drink-and-other-substances/moreThenOneUnit549x134.png |
|

|  |  |
| --- | --- |
| **Pint of regular beer (3.5%)**  | **2 units** |
| **Glass of Wine (175mls)** | **2 units** |
| **Single measure spirits (25mls)** | **1 unit** |
| **Bottle of wine (12%)** | **9 units** |
| **Bottle of Spirits (40%)** | **28-30 units** |
| **Can of strong cider (440mls 8.5%)** | **3.75 units** |
| **Bottle of alco-pops (330mls 5%)** | **1.7 units** |

 |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Medical Records Access**

**Consent Form**

I have read and understood the information leaflet about access to medical records, booking appointments online and ordering repeat prescriptions online.

I consent to my GP practice providing me access to my electronic health record via the internet.

I further agree to use the system in a responsible manner in accordance with all instructions given to me by the GP practice and to immediately report any errors I encounter whilst using the system.

If I see any patient data which does not relate to me I will immediately log out and report the matter to the GP practice

**Part access (appointments and repeat prescriptions)**

Name ……………………………………………………………………………..

Signed …………………………………………………… Date ……………….

Date of Birth………………………………………………………………………

Home Telephone No …………………………………………………………….

Mobile Telephone No…………………………………………………………….

Email Address

**(PLEASE NOTE: we can only use one email address per registration)**

…………………………………………………………………….

Please note: separate consent forms for other family members will be required