New Patient Registration Questionnaire – Adult

Please complete all information – 1 form is required for each new patient.

Your Details			
Title	Mr / Mrs / Miss / Ms		
First Name		**Surname**	
Date of Birth			
Gender			
Address			
Home Telephone Number		**Mobile Telephone Number**	
Email			
Are you happy to be contacted via email and text?	Email Yes / No	Text Yes / No	
Main Language Spoken			
Do you need an interpreter or any sign language assistance	Yes / No If yes please provide details:		
Do you have a Disability	Yes / No If yes please provide details:		
Please provide the name and location of the Pharmacy that you would like prescriptions to be sent to			

Carer Information	
Are you a carer, i.e. do you look after someone who couldn't manage without your help?	Yes / No
Does someone look after you (do you have a carer)?	Yes / No

Ethnic Group (please tick which applies)				
White	**Asian**	**Black**	**Mixed**	**Other**
British	Bangladeshi	African	White / Asian	Arab
Irish	Chinese	Caribbean	White / African	
Other	Indian	Other	White / Caribbean	
	Pakistani		White / Other	
	Other			
Any Other (please state)				
I do not wish to disclose (please tick)				

Next of Kin / Emergency Contact Information			
Title	Mr / Mrs / Miss / Ms		
First Name		**Surname**	
Relationship to you			
Their Address:			
Their Home Telephone Number		**Their Mobile Telephone Number**	

Military Veteran Information	
Are you a military Veteran? A military veteran is defined as someone who has served at least one day in Her Majesty's Armed Forces (Regular or Reserve) or Merchant Mariners who have seen duty on legally defined military operations	Yes / No
Do you consent to adding this information to your medical records? Administrative note: if yes to the above code as 13Ji	Yes / No

Medical Information

Do you suffer or have suffered from any of the following: (Please tick all that apply)		
Asthma	Epilepsy	Alzheimer's or dementia
Cancer	Heart Disease	High blood pressure (hypertension)
Mental Health	Liver/Kidney Problems	Thyroid
Diabetes	Stroke	
Other (please give details)		
Do you / have you ever suffered from any allergies (please circle)		Yes / No If Yes, please provide details:
Medication / Product / animal allergic to:	**Reaction i.e. rash / itch etc.**	

Smoking Status

Do you smoke? ***(Please circle)***	Yes / No / Ex-smoker
If 'Yes' or 'Ex-Smoker', how many do you or did you smoke per day?	
If 'Yes' are you interested in giving up smoking? (Please circle)	Yes / No

Current Medications

For Patients who regularly take prescribed medication: please provide further information about what medications you are currently taking including the name and the dosage if known.

For Women prescribed the oral contraceptive pill: we kindly request that you book an appointment for a pill check before your next prescription is due.

Patients Signature: ___________________________ **Date:** ____________________