Winterton Medical Practice

The Surgery Manlake Avenue Winterton DN15 9TA Telephone: (01724) 732202

CONFIDENTIAL REGISTRATION QUESTIONNAIRE

To help your doctor provide good medical care, please fill in the following details and hand in with your registration documents.

PLEASE REMEMBER TO SIGN THE LAST PAGE

SURNAME	Title:
FIRST NAME(s)	
Date of birth:	Age:
ADDRESS: Post code:	

Ethnic origin: (Please tick box)

White:
a) British
b) Irish
c) Other white background
(please specify)

Mixed:
d) White & black Caribbean
e) White and Black African
f) White and Asian
g) Any other mixed background
(please specify)

Asian or Asian background:
h) Indian
j) Pakistani
k) Bangladeshi
l) Any other Asian background
(please specify):

Black or Black British:
m) Caribbean
n) African
p) Any other black background
(please specify)

Chinese or other ethnic group:
r) Chinese
s) Any other ethnic group (please specify):

1) In which country were you born? ……..

2) Have you migrated to the UK recently from any country within the following continents (Please indicate)?:

Africa ☐ Asia ☐ The Caribbean ☐ Central & South America ☐
Eastern & Southern Europe ☐ The Middle East ☐ The Pacific Islands ☐

3) If you have come from abroad what date did you arrive in this country: ……

Do you have a visa or work permit? **YES/NO** **If YES please produce this at reception for photocopying**.

3) What is your first language? English Other (please state):

4) Is an interpreter required? Yes No

Telephone no: **Home:**	**Mobile:**
In order for you to receive communication from us VIA SMS we need you to confirm your consent to allow us to do this. To consent please tick this box. We hope that you will be happy for us to message you about your upcoming appointments, or services we offer and to gather	

your feedback to help us improve our services. **You can still "Opt Out" at any time if you wish.**	

Which area have you moved from?

Please give the full names of anyone else who lives at this address:

Name, Address and Telephone number of next of kin/carer:

Carers: If you are a carer for one of our registered patients please state patient name:
Name: Telephone no:
Address:

*(**Please ensure they have given you their permission to use this information**):*

FAMILY HISTORY: Please tell us if you have a family history of any of the following:

DISEASE	RELATION	Age of onset
Stroke		
Hypertension (high blood pressure)		
Diabetes Mellitus		
Cancer (please specify type)		
Heart disease – angina, MI, Heart attack, vascular disease.		
Any other, eg: (please tick box) Asthma Epilepsy Glaucoma		

Any other conditions you think we should know about?

Have you had any operations or significant medical condition?
Please state with dates:

YES / NO

ARE YOU TAKING ANY PRESCRIBED MEDICINES/TABLETS AT PRESENT?
If YES please list with dose and how often taken.

ARE YOU ALLERGIC TO ANY MEDICINES (EG PENICILLIN)? YES/NO

please state:

DO YOU HAVE ANY OTHER ALLERGIES? YES/NO

YOUR LIFESTYLE:

HEIGHT? WEIGHT?	
Do you smoke? If so, how much?	
If you have 'given up' when did you stop?	
How many units of alcohol do you drink on average per week? (please see attached guide) Units/week:	
Do you follow any diet (religious or medical?) **If yes please specify which**	**YES/NO**

Do you take any regular exercise? **If yes please specify which**	**YES/NO**
What is your occupation:	

HAVE YOU ANY DISABILITY? IF SO WHAT WOULD YOU LIKE US TO KNOW ABOUT IT

HEALTH PROMOTION:

Do you wish to receive any information on any of the following (TICK BOX IF YES)
ALCOHOL DIET OBESITY SMOKING EXERCISE
OSTEOPOROSIS

DO YOU HAVE ANY SERIOUS WORK PROBLEMS WHICH AFFECT YOUR HEALTH?

CURRENT HOSPITAL SPECIALIST TREATMENT:

So far as you are aware, are you currently on any waiting list within the NHS for **ANY** operation or outpatient appointments: **YES/NO**

Please give as full details as possible regarding the hospital, department, consultant and any operation or procedure awaiting (including the hospital number if known):

HOSPITAL	HOSPITAL NO	DEPARTMENT	PROCEDURE

FOR WOMEN ONLY:

1 **When was your last cervical smear**?

Date	Normal/abnormal

If it is more than 3 years since your last smear we can arrange one for you with the practice nurse.

2 **Have you had a HYSTERECTOMY?**

YES/NO	DATE IF YES:

3 **Have you ever had a MAMMOGRAM?**

YES/NO	DATE IF YES:	NORMAL/ABNORMAL

PLEASE DETAIL ANY IMMUNISATION DATES YOU HAVE RECORDED

	NO	YES	DATES		
Diphtheria					
Whooping Cough (Pertussis)					
Tetanus					
HIB Meningitis					
Polio (drops)					
MMR (measles, mumps, rubella)					
Any other?					

ADULTS

If you have had any travel vaccinations in the last **ten** years – please list below:

ANYTHING ELSE? Is there anything else you want your new doctors to know?

Thank you very much for your help. We cannot complete your registration until you have attended the surgery for a registration medical – PLEASE MAKE AN APPOINTMENT WITH THE PRACTICE NURSE AS SOON AS POSSIBLE or if you are on any medication you will need to see the doctor – ***please ask reception to make an appointment for you.***

PLEASE SIGN BELOW:

The information I have provided is correct and I apply to be included on the list of the Practice. I acknowledge receipt of an offer for a medical examination:

Signed: …….

Date: ……