**Bradley’s Practice Today’s Date:**

**New Patient Registration Form (V.11)**

**Document checked by (staff initials)\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient ID checked by (staff initials)\_\_\_\_\_\_\_\_\_\_\_\_**

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 box as appropriate.

If you are newly arrived in this Country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.

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| |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Full Name:** |  | | | **Telephone Number:**  **Mobile Number:**  **Work Number:** | | **Mr / Mrs / Miss / Ms / Other......** | | | |  | | | **Address and Postcode:** | | |  | | | | **Next of Kin Contact details:** | | | | | | | **PLEASE NOTE: YOU ARE RESPONSIBLE FOR KEEPING US INFORMED OF ANY CHANGES TO YOUR CONTACT DETAILS – PARTICULARLY IF YOU CHANGE YOUR MOBILE PHONE NUMBER – AS SOON AS POSSIBLE.** | | | | | |   **You may be contacted by text for the following:**  **1) To inform you about medical matters**  **2) To re-arrange an appointment**  **3) To send you reminders**  **If you give consent to receiving texts, then please tick YES. If you do not consent to receiving texts, please tick NO.**  **YES NO** |

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| **Date of Birth:** | |  | | **Previous**  **Surnames:** | |  | | |
| **Marital Status:** |  | | **Gender:** | | **Male** | | **Female** | **Occupation** |
| **Your main or first language spoken/understood:**  **Welsh speaker Y/N #13lz** | | | | | | | | |
| **Birthplace:** | | | | | | | | |
| **School (children & students only)** | | |  | | | | **NHS number** | |
| **E-mail address:** | | | | | | | | |
| **Your height:** | **Feet/inches** | | **cm** | | **Your weight:** | | **Stones/lbs** | **Kg** |

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| **Previous Doctor Name, Address & Postcode:** If you have changed GPs’ more than once within the last year please give the names of the surgeries you have been registered with (and dates) |

**Smoking, Alcohol Consumption and Exercise:**

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| **Are you currently a smoker** | | **Yes** | **No** | | | **Have you ever smoked** | | | **Yes** | **No** | |
| **If so, how many cigarettes/cigars/tobacco do you smoke in a week?**  If you are a smoker and want to stop, please ask for information about local smoking cessation services.  **Free Local Service 0800 085 2219** | | | |  | | | **How much alcohol do you drink in a week (units)?**  (One unit = 1 small glass of wine, a single measure of spirits or a ½ a pint of beer | | | | |
| **How often do you exercise?** | **No of times per week** | | | | **Type(s) of exercise:** | | |  | | |

**Alcohol Users Disorders Identification Test (AUDIT) C**

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| **QUESTIONS** | **0** | **1** | **2** | **3** | **4** | **Your Score** |
| How often do you have a drink that contains alcohol? | Never | Monthly or less | 2 -4 times per month | 2 – 3 times per week | 4 + times per week |  |
| How many standard alcoholic drinks do you have on a typical day when you are drinking? | 1 -2 | 3 -4 | 5 – 6 | 7 – 9 | 10 + |  |
| How often do you have 6 or more standard drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |

**Scoring:** A total of 5 + indicates hazardous or harmful drinking

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| **Your Medical Background:** |
| **What illnesses have you had & when?** |
| **What operations have you had & when?** |
| **Hearing loss #F59 y/n Visual impairment #F49, Y/N**  **Speech impairment #z567 Y/N**  **Do you have any medical problems at present?** |
| **Please list any tablets, medicines**  **Or other treatments you are**  **Currently taking:**  **(inc. Dose & frequency)**  If possible please provide the list from your last repeat prescription  **Preferred Chemist \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Are there any serious diseases that affect your parents, brothers or sisters (Please tick and state the family member affected and how old they were at the time)?**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Diabetes** | **Heart Attack** | **Cancer** | **Angina** | **Epilepsy** | | **Chronic Lung Disease** | **High Blood Pressure** | **Asthma** | **Stroke** | **Thyroid Disorder** | | **Any Other Important Family Illness?** | | | | |   **Immunisations**  **Please tick all vaccinations that you have had and supply dates where possible** |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Diphtheria** | **Measles** | **German Measles** | **Tetanus** | **Polio** | **MMR** | | **Whooping Cough** | | **Pre-school booster** | | **Triple Vaccine (Diphtheria, Tetanus & Pertussis) – 3 Doses** | | |

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| **Specific Needs:**  **Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:** | |
| **Do you have a diagnosed non-medical or medical allergy?** |  |
| **Do you require the help of a translator/interpreter?** |  |
| **Are you a Veteran?** |  |
| **Please state any physical or mental disabilities you have:** |  |

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| **For Patients aged 65 and over or those with a chronic disease (e.g asthma or diabetes)** | | | | | | | | |
| Have you had a flu vaccination? Enter date or “never” | | | | | |  | | |
| Have you had a pneumococcal vaccination? Enter date or “never” | | | | | |  | | |
| **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):** | | |  | |

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| **Are you a Carer?** | **Relationship to cared for person.** |
| **Details of person requiring care:**  **Name...............................**  **Date of Birth.........................** | **Is this person registered at this practice (please circle)**  **Yes                           No** |
| **As a Carer you may not know what help and information you may be entitled to. Newcis may be able to assist you with this.** | **Newcis**  **Corlan Unit 3  Mold Business Park**  **Wrexham Road**  **Mold. CH7 1XP**  **Tel No: 01352 744055**  **Email:**[**flintshire@newcis.org.uk**](mailto:flintshire@newcis.org.uk) **Website:** [**www.carers.org/local/wales/flintshire**](http://www.carers.org/local/wales/flintshire) |

Do you live in any of the areas listed below?

If so, please tick the relevant option and turn the page.

* **Cadole □**
* **Cilcain □**
* **Coed Talon □**
* **Eryrys □**
* **Graianrhyd □**
* **Gwernaffield □**
* **Gwernymynydd □**
* **Hendre □**
* **Higher Kinnerton □**
* **Leeswood □**
* **Llanferres □**
* **Llong □**
* **Loggerheads □**
* **Maeshafyn □**
* **Mynydd Du □**
* **Nannerch □**
* **Nercwys □**
* **Padeswood □**
* **Pantymwyn □**
* **Pontblyddyn □**
* **Potybodkin □**
* **Rhosesmor □**
* **Rhydymwyn □**
* **Tafarn Y Gelyn □**
* **Treuddyn □**

As a dispensing practice we are able to dispense your medication from the surgery. Regulations only allow us to offer this service to patients registered with us who **live more than 1 mile from their nearest pharmacy and who live in a rural area.**

**I would / would not (**please delete as appropriate), like the practice to dispense my medication.

**If you would like** the practice to dispense your medication please sign and date the consent details below.

I confirm that I **live more than 1.6kms** (approx 1 mile) from my nearest pharmacy and I provide consent to Bradleys Practice to dispense medicines and appliances to me. I will instruct you where I want my medications to be picked up from i.e Mold or Buckley surgeries each time I request an item.

**Patient Name**:......................................................................

**Date of Birth**:.......................................................................

**Patient Signature**:................................................................

**Date**:......................................................................................

**For more information about the services we offer please see our website:** [**www.bradleys.practice.co.uk**](http://www.bradleys.practice.co.uk)

**Through our website you can also access ‘My Health Online’ an internet service for ordering medication + creating and cancelling appointments. If you wish to sign up to this service then feel free to ask one of our receptionist for a form to fill out.**

**If you wish to see your summary report in the future then please tick either of the following boxes:**

**YES NO**

**THANK YOU FOR COMPLETING THIS FORM.**

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