**York Road Surgery**

**NEW PATIENT REGISTRATION QUESTIONNAIRE**

If the surgery has a mobile phone number and email address recorded for you we will automatically send appointment confirmations and reminders and other appropriate messages to you unless you let us know otherwise. Any information sent will be relevant to your healthcare, and will not be from any third-party companies.

If you do not wish us to send you information in this way, please let us know.

**PERSONAL DETAILS** (\* Circle as appropriate)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| First Name: | Mast | Mr | Mrs | Miss |  |
| Surname: | Address: |
| Date of birth : / / |  |
| Gender: | M | F | Postcode: |
| Employment status: | Home 🕿: |
| First Language: | Mobile 🕿: |
| Email Address: |
| Marital Status:\* | Single | Married | Divorced | Widowed |
| Ethnicity:\* |
| African | Bangladeshi/British Bangladeshi |
| British or Mixed British | Caribbean |
| Chinese | Indian or British Indian |
| Irish | Other Asian Background |
| Other Black Background | Other mixed background |
| Other White Ethnic Group | Other: |

**NEXT OF KIN DETAILS**

|  |  |
| --- | --- |
| First Name: | Surname: |
| Address : | Home 🕿: |
|  | Mobile 🕿: |
| Postcode: | Relationship to yourself: |

**GENERAL HISTORY**

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| --- |
| Name of previous GP and Address: |
|  |
| Have you had any serious illness? | Yes | No |
| (If yes, please list) |
|  |
|  |
|  |
| Are you registered disabled? | Yes | No |
| (If yes, please give details) |
|   |
|  |
| Do you have any allergies? | Yes | No |
| (If yes, please list) |
|  |

**HEALTH**

|  |  |  |  |
| --- | --- | --- | --- |
| Do you smoke?\* | Yes, I smoke….per day | I’ve stopped | I’ve never smoked |
| Do you drink alcohol? | Yes | No |
| (If yes, how many units per week?): |
| Do you exercise? | Yes | No |
| (If yes, how often?): |  |  |
| Height: | Weight: |

**PLEASE LIST ANY MEDICATION**

|  |  |  |
| --- | --- | --- |
| Name | Dose | Frequency taken |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
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|  |  |  |
|  |  |  |
|  |  |  |

**FEMALE PATIENTS ONLY**

|  |  |  |
| --- | --- | --- |
| Have you had a hysterectomy?\* | Yes | No |
| When was your last smear? |
| Date: | Result: |
| Do you have any gynaecological problems?\* | Yes | No |
| (If yes, please state) |

|  |
| --- |
| Please tell us why you have chosen this Practice: |
|  |
|  |
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| --- |
| Please give any additional information that you would like us to be aware of: |
|  |
|  |
|  |
|  |
|  |

**Do you consent to sharing your medical records with other healthcare providers?**

**Yes**

**No**

**For further information on this question please ask a member of staff**

**Patient Signature:**

**Date completed:**