Grange Farm
Medical Centre

New Patient Registration Questionnaire Form

Patient Details

Title	Mr / Mrs / Miss / Ms / Other (delete as appropriate)		Address		
First Name					
Middle Name					
Surname			Home Tel. No		Preferred contact Yes/No
Date of Birth			Mobile Tel. No		Preferred contact Yes/No
NHS Number			Email address		

Ethnic Origin

White	British / Irish / Other (delete as appropriate) .....
Mixed	White & Black Caribbean / White & Black African / White & Asian / Other (delete as appropriate) .....
Asian or Asian British	Indian / Pakistani / Bangladeshi / Other (delete as appropriate) .....
Black or Black British	Caribbean / African / Other (delete as appropriate) .....
Chinese or other Ethnic Group	Chinese / Other (delete as appropriate) .....
	I do not wish to specify my ethnic origin

Spoken Language

Main Spoken Language	
Do you speak English	Yes / No (delete as appropriate)
Do you need an interpreter?	Yes / No (delete as appropriate)

About You

Have you ever been a member of HM Armed Forces?				Yes / No (delete as appropriate)	
Are you originally from Abroad?	Yes / No (delete as appropriate)			If so, when did you arrive in the UK?	
Next of Kin (optional)				Relationship to you	
Next of Kin address				Next of kin contact Telephone number	
Do you consent to receiving text messages to your mobile phone?				Yes / No (delete as appropriate)	
Do you consent to us contacting you via e-mail?				Yes / No (delete as appropriate)	
Would you like to register for on-line services / NHS App?				Yes / No (delete as appropriate)	
Have you received a copy of our leaflet about Record Sharing?				Yes / No (delete as appropriate)	
Are you a carer?	Yes / No (delete as appropriate)			Who do you care for?	
Are you a cared for?	Yes / No (delete as appropriate)	Who is your carer?	Carers Name		Carer's contact Tel No.
What is your occupation? (This information could help us identify causes of any symptoms you may come to see us about)					

17a Tremayne Road, Bilborough
Nottingham, NG8 4HQ
Tel: 0115 896 5002

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Medical Questions about you

Do you have any known allergies?	Yes / No (delete as appropriate)				
If yes, details					
Do you consider yourself to have a disability?	Yes / No (delete as appropriate)				
If yes, details					
Are you a smoker? (Please tick appropriate box)	No Never				
	Ex-smoker		When did you quit?		
	Smoker		How many per day?		
Would you like help to stop smoking?	Yes / No (delete as appropriate)				
Alcohol Assessment					
Questions in relation to the past year	**Please circle your answer**				
How often do you have an alcoholic drink?	Never	Monthly or less	2 - 4 times per month	2-3 times per week	4 or more times per week
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 – 4	5 - 6	7 - 8	10 or more
How often do you have 6 or more units on a single occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often have you failed to do what was normally expected of you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often have you needed an alcoholic drink in the morning, after drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often have you felt guilty after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often have you been unable to remember what happened the night before as a result of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Have you or anyone else been injured as a result of you drinking?	No		Yes, but not in the last year		Yes, during the last year
Has a relative, friend, 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

Patient Declaration

To the best of my knowledge, all the preceding answers and information provided are true and correct	
Signature	
Print Name	
Date	

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