

YSTRADGYNLAIS GROUP PRACTICE

NEW PATIENT REGISTRATION FORM

Please print clearly

Title _____ Date _____

Surname _____ First Name/s _____

Date of Birth _____ Home Tel. Number _____

Mobile Tel Number _____

E-mail address _____

Please confirm if you give consent for us to:

Send SMS text messages Yes / No and emails using the above information. Yes / No

Please see attached information about consent.

Address _____

_____ Postcode _____

Previous GP: _____

Place of Birth: Town/City _____ Country _____

Which ethnic group do you belong to? (Please tick one)

British/Mixed British Irish Other White background White & Black Caribbean White & Black African

White & Black Asian Other Mixed Background Indian/ British Indian Pakistani/British Pakistani Chinese

Bangladeshi/British Bangladeshi Other Asian background Caribbean African Other Black Background

Other ethnic group (please give details) _____

Preferred Language _____

Next of kin (full name) _____ Tel. Number _____

Address _____

Relationship to next of kin: _____

Have you ever been in the H M Forces? Yes / No

Looking after Someone

| | |
|---|----------------------|
| Are you looking after someone? Let us know if you are looking after someone who is ill, frail, disabled or has mental health and/or emotional support needs, or substance misuse problems. | Yes / No |
| Is someone looking after you? Let us know if a family member, friend or neighbour looks after you. If yes, they are your carer. You are welcome to invite your carer to accompany you to visits at the practice | Yes / No |
| Carers Name: | Relationship to you: |
| Address of Carer: | |
| Telephone number of carer: | |

If you would like more information please on carers please speak to a receptionist.

Medical History

Do you suffer from: (please circle)

Asthma Yes / No Cancer Yes / No

Diabetes Yes / No Epilepsy Yes / No

Heart Disease Yes / No High Blood Pressure Yes / No

Hypothyroidism Yes / No Strokes Yes / No

COPD Yes / No Other _____

Please provide date of last review _____

Have you ever had any other operations or illnesses? (E.g. tonsils removed etc.) Yes / No

If yes, (please list below and give dates where possible)

MENACWY Vaccination (only for patients between 9 – 25 years old)

When did you receive your MENACWY vaccination Date given _____

Family History

Has anyone in your immediate family suffered with: (please circle)

Asthma Yes / No Cancer Yes / No Diabetes* Yes / No

*Do you consent to a Diabetic risk assessment Yes / No

Heart Attack Yes / No Stroke Yes / No High Blood Pressure Yes / No

Other _____

General Health and Social History (please circle)

Marital Status? Single Married Divorced Widowed

Occupation _____

Do you smoke? *Have never smoked*

Current Smoker How many per day? ____ Would you like more info on our stop smoking program Yes No

Ex-smoker - How long did you smoke for? _____ How many per day did you smoke? _____

Alcohol intake: On average, how many units do you drink per week? _____

(Half a pint of beer = a glass of wine = one measure = one unit of alcohol)

Do you take regular exercise? No Yes How often? _____

Height _____ Weight _____ Waist Circumference _____

Do you have any allergies? (E.g. aspirin, penicillin) No / Yes (give details) _____

Are you on any regular medication? No / Yes (give details)

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Have you ever used any other drugs _____

SPECIFIC QUESTIONS FOR FEMALE PATIENTS

What do you use as contraception?

Contraceptive Pill Name _____

Injection Date last given _____

Diaphragm Condom only Contraception not required

Would you like to discuss these methods of contraception? Coils/injections/implant Yes / No

Date of last Smear __ / __ (mm/yy)

Result _____

Place of Procedure (please circle) Family Planning Clinic GP Surgery Outpatient Clinic

Other (please state)

Patient Consent for Email and Text Message Communication

The practice wishes to expand its methods of communicating with patients to include the use of email and text messaging.

Patient Privacy is important to us. We would like to communicate with you regarding any activities that may be of interest, which means that we need your consent.

This may include using emails to:

- provide updates on new developments at the practice
- the use of text messaging to send patients reminders about the details of their next appointment
- Provide test results and changes in medication

Emails and text messages are generated using a secure facility, but because they are transmitted over a public network they may not be secure. Email and text communication will never be used for urgent communications. Your contact details will be used solely in relation to healthcare services offered by the practice, and you can choose to opt out of the services at any time by speaking to a Patient Coordinator.