NEW CLIENT REGISTRATION AND QUESTIONNAIRE

This questionnaire is designed to help your new GP get to know you, your lifestyle, and some of your relevant medical history. You do not have to answer all questions; although it will greatly assist your doctor in providing the best possible care by completing this form as fully as possible.

Your Personal details

Title:		Current Address:				
Surname:						
Forename(s):						
D.O.B:						
Home Telephone:						
Mobile Telephone:						
Occupation:						
Email Address:						
Status:	Single ☐	Married ☐	Separated ☐	Divorced ☐	Widowed ☐	In Partnership ☐
Do you require a Chaperone?	Yes ☐		Do you require an English translator?	Yes ☐		

Your Next of Kin

Next of Kin:		Next of Kin Address:
Relationship:		
Contact Tel. No.:		

For Patients Under 18 years of age

Legal Guardian:		College / School / Pre-school / Nursery Address:
Name of school / college:		
Tel. of school / college:		
Teacher' Name:		

Details of Your NHS GP

Practice Name:		Practice Address:
Telephone Number:		
Usual Doctor:		
NHS Number: (If Known)		

Insurance & Private Medical Care Details

Private Medical Insurer:		Insurer Client No.:	
Bupa Membership No.:		Self Pay / Other:	

How did you hear about us?

☐ Refer a friend ☐ Advertisement ☐ Recommendation	☐ Insurance Company ☐ Consultant / Nurse ☐ Other	*Please give details if possible*

General Health Information

Height:	Weight:	Blood Pressure (if known):

Disability

Do you have a disability or Long Term condition?	Yes ☐	*Give details*	*Continue on a separate sheet*
Do you have a carer?	Yes ☐	Are you house bound?	Yes ☐

Medical History

Heart Disease	Yes ☐	Epilepsy	Yes ☐	Rheumatoid Arthritis	Yes ☐
Stroke	Yes ☐	Mental Health	Yes ☐	Rheumatic Fever	Yes ☐
Diabetes (Type 1 ☐ / Type 2 ☐)	Yes ☐	Thyroid	Yes ☐	Jaundice	Yes ☐
High Blood Pressure	Yes ☐	Cancer	Yes ☐	Blood disorders	Yes ☐
Asthma	Yes ☐	Osteoporosis	Yes ☐	Fainting Attacks / Blackouts	Yes ☐
Other					Yes ☐

Approx. date(s) of diagnosis	*Continue on a separate sheet*
Have you been referred for treatment or investigation(s) in the last 5years?	*Please specify nature and date(s)* *Continue on a separate sheet*
History of previous surgery	*Please specify nature and date(s)* *Continue on a separate sheet*
Known Allergies:	*Continue on a separate sheet*
Are there any other medical details about yourself that we should be aware of?	*Continue on a separate sheet*

Family History (Parents, Brothers & Sisters)

Heart Disease	Yes ☐	Age **At** Diagnosis	Under 60 ☐ Over 60 ☐
Stroke	Yes ☐		Under 60 ☐ Over 60 ☐
Diabetes	Yes ☐		Under 60 ☐ Over 60 ☐
High Blood Pressure	Yes ☐		Under 60 ☐ Over 60 ☐
Asthma	Yes ☐		Under 60 ☐ Over 60 ☐
Cancer	Yes ☐		Under 60 ☐ Over 60 ☐

Your Lifestyle

I have never smoked	Yes ☐		
I am a current smoker	Yes ☐	*How many per day?*	…but, I would like to STOP smoking ☐
I am an ex-smoker	Yes ☐	*When did you give up?*	

	Never	Less than monthly	Monthly	Weekly	Daily / almost daily
***MEN**:* How often do you have **8** or more drinks on one occasion? ***WOMEN**:* How often do you have **6** or more drinks on one occasion?	☐	☐	☐	☐	☐
How often in the last year have you been unable to recall what happened the night before because you had been drinking?	☐	☐	☐	☐	☐
How often in the last year have you failed to do what was normally expected of you because of drinking?	☐	☐	☐	☐	☐

In the last year has anyone been concerned about your drinking or suggested that you cut down?	No ☐	Once ☐	More than once ☐
On average, how many units of alcohol do you drink in a week?	*units*	*1 unit = half pint beer / 1 glass wine / 1 spirit shot*	

In an average week how often do you exercise *(raise your heart rate)* for more than 20mins?	☐	No regular exercise	☐	Once or twice a week	☐ Twice a week or more

Women

Pregnancies: *What Year(s)?*	Are you expecting a baby?		*When*
Any Known Problems? *Please state*			
Last Cervical Smear	*When*		*Where*
Are you taking the contraceptive pill?	Yes ☐	No ☐	*Which*
Are you using any other contraception?	Yes ☐	No ☐	*What*
Date of last mammogram (*50 to 65 years of age only*)	*When*		

Current Medication

Are you taking repeat medication?	Yes ☐	No ☐	*Please give details on a separate sheet and attach a copy of your current medication repeat form if you have one, alternatively bring along the packaging!*
Are you allergic to any medication?	Yes ☐	No ☐	
Are you taking any non-prescribed drugs or medication?	Yes ☐	No ☐	
Have you ever had a reaction to anaesthetic?	Yes ☐	No ☐	*What*

Immunisations & Vaccinations

Name of Medication:	Last Immunisation Date:

Continue on a separate sheet

Other professionals involved in my care

Name:	Team:	Telephone:

Continue on a separate sheet

Sickness record over the last three years

Please give details of any relevant certified time off work, school or college you has taken in the past three years.

Date:	Time Off:	Cause:

Continue on a separate sheet

Thank you for completing this form as fully as you can, this information forms part of your medical records while registered at The Trinity Private Practice.

Please return the completed form, along with any supporting information to:

Baytrees
Boxted Church Road,
Gt. Horkesley,
Essex,
CO6 4AL