HANWAY MEDICAL PRACTICE

FOR INFORMATION:

All new patients will be asked to produce a document to prove personal and residential identification when registering with our Practice;

This needs to be one from each of the groups below:-

Group 1 (as proof of identity)

Birth Certificate
Marriage Certificate
Passport
Medical Card
Driving Licence
National Insurance Card

AND

Group 2 (as proof of address)

Local Authority Rent Card
Paid Utility Bill
Bank Statements

IF YOU DO NOT PRODUCE THE NECESSARY I.D. AT THE TIME OF REGISTRATION YOU WILL BE ASKED TO PRODUCE IT WITHIN 4 WEEKS OF YOUR REGISTRATION APPOINTMENT

Please note that if you do not inform us that you are unable to attend your registration appointment you will not be given another appointment and will need to register with another Practice.

NEW PATIENT DETAILS – 14 YEARS AND OVER

DATE OF REGISTRATION APPOINTMENT: _____

Personal Details:

Surname: _____ Forename: _____ DOB: _____

Maiden Name: _____

Sex: MALE/ FEMALE Occupation: _____

Address: _____

Postcode: _____ Place / Country of Birth _____

Marital Status: SINGLE / MARRIED / SEPARATED / DIVORCED / WIDOWED / OTHER

Telephone Contact Details:
Home: 023 92 _____ Work: _____ Mobile: _____

Next of Kin – relationship: _____

Previous Doctor (name and address): _____

_____

Personal Medical History:

Please list any serious or longstanding illnesses – operations – disabilities:

Problem: _____

Date and year: _____

Have you ever suffered from?

Coronary Heart Disease	YES / NO	Blood Pressure	YES / NO
Stroke	YES / NO	Diabetes	YES / NO
Asthma	YES / NO	C.O.P.D.	YES / NO
Cancer	YES /NO	Epilepsy	YES / NO
Hyperthyroidism	YES / NO	Mental Health Problems	YES / NO
Blindness – Glaucoma	YES / NO	Eczema	YES / NO

Family Medical History: (parents, brothers, sisters ONLY)

Blindness	YES / NO	Glaucoma	YES / NO
Epilepsy	YES / NO	Cancer	YES / NO
Diabetes	YES / NO	Heart Attack	YES / NO
Asthma	YES / NO	Eczema	YES / NO
Stroke	YES / NO	Blood Pressure	YES / NO

If you have ticked any of the above please state: Approximate date – relationship – condition

Are you a Veteran (i.e. served in one of the armed forces for at least one day): YES / NO

Personal Habits / Lifestyle:

Exercise: do you undertake regular sport or exercise? NEVER / DAILY / WEEKLY

Diet: do you eat a healthy diet? YES / NO / SOMETIMES

Smoking: have you ever smoked: YES / NO

Do you currently smoke? YES / NO How many a day: _____

If you would like to give up smoking there is help.
Well Being Service – telephone number: 023 9229 4001

Alcohol Consumption: How many units per week? _____
(1 pint = 2 units, 1 glass of wine/ 1 short = 1 unit)

Question	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 wee	4+ times per week	
How many units of alcohol do you drink on a typical day?	1 – 2	3 – 4	5 – 6	7 – 8	10+	
How often do you had 6 or more standard drinks on one occasion	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
Scoring: A total of 5 or more indicates Hazardous or Harmful drinking						

Full Audit done: YES / NO (38D3.00) / DECLINED (8HA5 – Follow-up refused))

Advice given by Health Professional: YES / NO

Referral to Alcohol Intervention Team (8HKG): YES / NO

Drugs and Medicines:

Are you currently taking any drugs or medicines: YES / NO
If yes, please list all names and doses:

Are you allergic to any substances? YES / NO
If yes, please specify:

Would you like to join the Patient Participation Group? YES / NO

FOR MEN: Do you examine your testicles? YES / NO

FOR WOMEN ONLY:

Do you examine your breasts? ` YES / NO

Have you, or do you attend a Family Planning Clinic? YES / NO

Do you use contraception? If yes, what method: _____

If the pill, please state which one and how long you have been taken it for: _____

Have you had a hysterectomy? YES / NO

When was your last smear: _____ where taken: _____

Are you currently trying for a baby? YES / NO

If yes, are you taking Folic Acid? YES / NO

Have you ever had a breast x-ray or mammogram? YES / NO

Have you ever been pregnant YES / NO → How many children do you have: _____

Vaccinations: (For 14 – 18 year olds)

Please state approx dates of your last injections:

Booster (14 years) ……

Carers Information

Are you a Carer for a relative? (e.g. Mother, father child with special needs etc) YES / NO

If yes, are they a patient at this Practice? YES / NO

If yes, please give name: ……

Do you need advice or help? YES / NO

To be completed by Nurse / HCA

BP: _____

WT: _____

HT: _____

I.D SEEN YES / NO (take a photocopy of documents and attach to the form)

Named GP Letter given to Patient aged 75 or over – YES / NO

SIGNATURE: _____