WHITELADIES MEDICAL GROUP

Patient Registration Form

Please complete both sides of the questionnaire as accurately as possible.

Name: ……

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐ ……

Address:
(Including Postcode) ……

……

Date of Birth: ……

Home Telephone Number: ……

Work Telephone Number: ……

Mobile Telephone Number: ……

Please sign to give permission for us to text you: ……

E-mail Address: ……

Please tick if you would not like to receive general health service information from us ☐ **Your e-mail address will not be disclosed to anyone else.**

Religion: ……

Smoking:

Have you ever smoked tobacco?	YES ☐	NO ☐
If YES to previous question, do you still smoke?	YES ☐	NO ☐
If you no longer smoke, when did you quit?	……	
How much do you/did you smoke per day?	……	
Do you know we offer help to stop smoking?	YES ☐	NO ☐
Would you like smoking cessation advice?	YES ☐	NO ☐

Alcohol:

How much alcohol do you drink in an average week?

Pints of beer/lager?	……
Glasses of wine?	……
Spirits? (pub measure - please see reverse)	……
Teetotal?	……

Allergies:

Are you allergic to any drugs, medicines or dressings? YES ☐ NO ☐

If yes, please give details: ……

Exercise:

How much exercise do you take a week? (please tick)

Nil	☐
Less than 1 hour (light exercise)	☐
1 ½ - 4 hours (moderate exercise)	☐
Over 4 hours (heavy exercise)	☐

Height: ……

Weight: ……

Next of Kin: Name: ……

Please Specify Relationship: ……

Contact Telephone Number: ……

The name and number of your next of kin will be added to your medical record.

Female Patients Only:

Date of last smear: ……

Family History: Please tick to indicate the family member, problem and age.

	Under 60	Over 60
Mother		
Heart Problems	☐	☐
Glaucoma	☐	☐
High Blood Pressure	☐	☐
Cancer (please specify):	☐	☐
……		
Father		
Heart Problems	☐	☐
Glaucoma	☐	☐
High Blood Pressure	☐	☐
Asthma	☐	☐
Diabetes	☐	☐
Cancer (please specify):	☐	☐
……		
Grandmother		
Heart Problems	☐	☐
Glaucoma	☐	☐
High Blood Pressure	☐	☐
Asthma	☐	☐
Diabetes	☐	☐
Cancer (please specify):	☐	☐
……		
Grandfather		
Heart Problems	☐	☐
Glaucoma	☐	☐
High Blood Pressure	☐	☐
Asthma	☐	☐
Diabetes	☐	☐
Cancer (please specify):	☐	☐
……		
Brother		
Heart Problems	☐	☐
Glaucoma	☐	☐
High Blood Pressure	☐	☐
Asthma	☐	☐
Diabetes	☐	☐
Cancer (please specify):	☐	☐
……		
Sister		
Heart Problems	☐	☐
Glaucoma	☐	☐
High Blood Pressure	☐	☐
Asthma	☐	☐
Diabetes	☐	☐
Cancer (please specify):	☐	☐
……		

WHITELADIES
MEDICAL GROUP

Are you a Carer?

Are you a Carer? Yes ☐ No ☐

If yes, please give details of the person who you care for:

Name of person you care for: ……

Relationship of person who you care for: ……

Medical condition of person you care for: ……...

Is the person you care for a registered patient of this surgery? Yes ☐ No ☐

Do you want more information on the benefits of being a carer? Yes ☐ No ☐

Are you cared for by a Carer?

Are you cared for by a Carer? Yes ☐ No ☐

If yes, please give details of the person who cares for you:

Carers name: ……

Carers relationship to you: ……

Carers contact details: ……

……

Telephone number: ……

Is the person who cares for you, a registered patient of this surgery? Yes ☐ No ☐

If you would like more information on Carers and being a Carer, please ask at the reception desk for a Carer's Information Pack

WHITELADIES MEDICAL GROUP

Alcohol Users Disorders Identification Test (Audit)

Units of Alcohol:

1 x pint of beer/lager/cider	2 units
1 x bottle of alcopop or can of lager	1.5 units
1 x 175ml glass of wine	2 units
1 x single measure of spirits	1 unit
1 x bottle of wine	9 units

Questions:	**Scoring System**					**Your Score**
	0	**1**	**2**	**3**	**4**	
How often do you have a drink that contains alcohol?	Never	Monthly or less	2 – 4 times per month	2 – 3 times per week	4 + times per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1 – 2	3 – 4	5 – 6	7 – 8	10 +	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you found you were not able to stop drinking once you started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0–7 = Sensible drinking; 8–15 = hazardous drinking; 16–19 = harmful drinking; 20+ = possible dependence

WHITELADIES MEDICAL GROUP

Patient Profiling Form

Practice / GP: …… Date of Birth: ……

Patient Name: …… Post Code: ……

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1. What do you consider to be your ethnic origin?

Asian or Asian British
- ☐ Bangladeshi
- ☐ Indian
- ☐ Pakistani
- ☐ Asian other (please state)

……

White
- ☐ British
- ☐ Irish
- ☐ White other (please state)

……

Black or Black British
- ☐ African
- ☐ Somali
- ☐ Caribbean
- ☐ Black other (please state)

……

Other Ethnic Group
- ☐ Chinese
- ☐ Any other (please state)

……

Mixed Background
- ☐ White and Asian
- ☐ White and Black African
- ☐ White and Black Caribbean
- ☐ Other mixed background (please state)

……

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2. In the clinic, which language do you <u>usually</u> speak and read?

Speaking	Reading		Speaking	Reading	
☐	☐	English	☐	☐	Polish
☐	☐	Albanian	☐	☐	Punjabi
☐	☐	Bengali	☐	☐	Russian
☐	☐	Cantonese	☐	☐	Somali
☐	☐	Farsi	☐	☐	Spanish
☐	☐	French	☐	☐	Turkish
☐	☐	Gujarati	☐	☐	Urdu
☐	☐	Hindi	☐	☐	Other (please state)
☐	☐	Mandarin			……

Thank you for helping us.

☐ I do not wish to complete this form.

If you need this document in a different format please telephone 0117 900 2287.