



# Allerton Road Medical Centre

## Patient Registration Form

### Personal details

**Title:**

**Surname:**

**First name(s):**

**Sex: (please tick)**

- Male
- Female
- Prefer not to say

**Date of birth:**

**Home Address:**

**Post Code:**

**Home telephone number:**

**Work telephone number:**

**Mobile telephone number:**

**Email:**

**Name and address of last GP (if you have registered before):**

**Birth town:**

**Birth country:**

### **If you are from abroad**

**Date you first came to live in UK:**

### **Communication support needs**

**Do you have any information and communication support needs? For example, would you like information in **Large Print** or **Easy Read** format? Do you use a hearing aid or communicate in **British Sign Language**? Do you need a language interpreter?**

**Please tell us your preferences:**

**What is your main spoken language?**

**Do you need an interpreter?**

- Yes
- No

**My GP can share my communication needs and preferences with other health services.**

- Yes
- No

**Are you happy for us to contact you by text?**

- Yes
- No

**Are you happy for us to contact you by email?**

- Yes
- No

### **Additional personal details**

**Next of kin:**

**Relationship to you:**

**Phone number:**

**Marital status:**

- Married
- Single
- Other

**Are you housebound?**

- Yes
- No

**What is your occupation?**

- Employed full time
- Employed part time
- Housewife/husband
- Retired
- Unemployed
- Long term sick benefit
- Student

**Are you a Carer?**

- Yes
- No

**If yes, who are you a Carer for?**

**Please ask for a Carer's pack from reception.**

**Do you have a Carer?**

- Yes
- No

**If yes, what is your Carer's name and contact information?**

**Are you happy for us to contact your Carer about you?**

- Yes
- No

## **Ethnic Group**

**Please tick below which best describes your ethnicity:**

- White British
- White Irish
- Any other white background
- Pakistani or British Pakistani
- Bangladeshi or British Bangladeshi
- Indian or British Indian
- Any other Asian background
- Mixed White & Black Caribbean
- Mixed White & Black African
- Mixed White & Asian
- Any other mixed background
- Black or Black British, Caribbean
- Black or Black British, African
- Any other Black background
- Chinese
- Any other ethnic group

## **If you are returning from the Armed Forces:**

**Address before enlisting:**

**Enlistment date:**

**Service or Personnel Number:**

## **Medical history**

**Please use the space below to list any current medications you are taking and the dosage**

**If you have a copy of your repeat medications, please pass to the reception to copy**

**Please list any allergies you have to any drugs/medication and the reaction you had:**

**Have you ever suffered from any important medical illness, had a major operation or have been admitted to hospital? If so please enter the details below:**

**Conditions might include: Diabetes, High blood pressure, Stroke, Osteoporosis, a DEXA scan, Epilepsy, Asthma, Allergies or Hayfever, Eczema, Depression or Anxiety, Cancer.**

**Condition:**

**Year diagnosed:**

**Is it ongoing?**

- Yes
- No

**Condition:**

**Year diagnosed:**

**Is it ongoing?**

- Yes
- No

**Condition:**

**Year diagnosed:**

**Is it ongoing?**

- Yes
- No

## **Immunisations**

**Please state which immunisations you have had in the last ten years including flu vaccinations.**

## **Family history**

**Have any close relatives (*father, mother, sister, brother only*) ever suffered from any of the following: (please indicate who)**

- **Heart attack**
  - Yes
  - No

**Relative:**

- **Stroke**
  - Yes
  - No

**Relative:**



- **Diabetes**

- Yes
- No

**Relative:**

- **High blood pressure**

- Yes
- No

**Relative:**

- **Asthma**

- Yes
- No

**Relative:**

- **Glaucoma**

- Yes
- No

**Relative:**

- **Cancer**

- Yes
- No

**Relative:**

## **Questions for women only**

**Which method of contraception (if any) are you using at present?**

**Have you had a cervical smear test?**

- Yes
- No

**Date (if known):**

**If yes, what was the result? (if known)**

- Normal
- Abnormal

**Have you ever had an abnormal results?**

- Yes
- No

**Have you had a chlamydia test?**

- Yes
- No

**Date (if known):**

## **Lifestyle: If you smoke or have ever smoked**

**If you smoke cigarettes, how many cigarettes do you smoke?**

- Less than 1/day
- 1-9/day
- 10-19/day
- 20-39/day
- 40+/day

**If you smoke a pipe, how many cigars do you smoke daily?**

**If you smoke a pipe how many ounces do you smoke a week?**

**Would you like help to quit smoking?**

- Yes
- No

**Are you an ex-smoker?**

- Yes
- No

**If yes, when did you give up?**

## Lifestyle: If you drink alcohol

How many units per week:

How often do you have a drink that contains alcohol?

- Never (0)
- Monthly or less (1)
- 2-4 times per month (2)
- 2-3 times per week (3)
- 4+ times per week (4)

How many standard alcoholic drinks do you have on a typical day when you are drinking?

- 1-2 (0)
- 3-4 (1)
- 5-6 (2)
- 7-9 (3)
- 10+ (4)

How often do you have 6 or more standard drinks on one occasion?

- Never (0)
- Less than monthly (1)
- Monthly (2)
- Weekly (3)
- Daily or almost daily (4)

**TOTAL SCORE =**

## Lifestyle - exercise

What exercise do you do?

- Heavy
- Moderate
- Light
- No Exercise

How many times a week?

## Health checks

If you are aged 40 - 74 would you like a health check?

- Yes
- No

## If you are aged over 16

Would you like an HIV test?

- Yes
- No

## **NHS Organ Donor registration**

**I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the options that apply.**

- Any of my organs and tissue or
- Kidneys
- Heart
- Liver
- Corneas
- Lungs
- Pancreas
- Any part of my body

**Signature confirming my agreement to organ/tissue donation**

**Date:**

**For more information, please ask at reception for an information leaflet or visit the website**

**[www.uktransplant.org.uk](http://www.uktransplant.org.uk), or call 0300 123 23 23.**

## **NHS Blood Donor registration**

**I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.**

**Have you given blood in the last 3 years?**

- Yes
- No

**Signature confirming consent to inclusion on the NHS Blood Donor Register**

**Date:**

**For more information, please ask for the leaflet on joining the NHS Blood Donor Register**

**My preferred address for donation is: (only if different from above, e.g. your place of work)**

**Postcode:**

## Summary Care Record

If you have a Summary Care Record your health care providers can view information about your medical needs when you're admitted to hospital, when treating you in an emergency, or when your practice is closed. The information they can see is your:

- current medication
- bad reactions to medicines
- allergies

I want to have a Summary Care Record.

- Yes
- No



## Patient Participation Group

**Would you be interested in joining our Patient Participation Group?**

- Yes
- No

This is a group of patient representatives that meet at least four times a year to help make sure there is a good channel for getting patients' views and input to the services offered by the practice. Please see our leaflet or ask reception for further details.

**Signature of Patient**

**Signature on behalf of Patient**