**St. George’s Crescent Surgery**

**New Patient Registration Questionnaire**

**Please complete this form in black ink and tick the boxes which are applicable.**

Do you require this form in larger print? Yes No

Are you classified as having a disability? Yes No

If yes, please state the disability................................................................................................................

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| --- | --- | --- | --- | --- | --- | --- |
|  Title: Dr / Mr / Mrs / Ms / Miss (please delete as required)  Forename: ................................................................ Surname: .................................................................. Address: .................................................................... .................................................................................. .................................................................................. .................................................................................. Postcode: ..................................................................  Home Phone Number: .............................................. Mobile Number: ....................................................... Work Number (if applicable): ................................... Email: .......................................................................  |

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 Marital Status: Married

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 Single

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| --- |
|   |

 Divorced

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|   |

 Co Habit

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|   |

 Widowed  |
|  Date of Birth: .............../........../..........   |
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 Dependants: Yes No  If yes, how many: .............................................. Next of Kin: ......................................................... Relationship to Yourself: .................................... Contact Number: ................................................  |
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 Have you been registered at this Practice previously? Yes No

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 Do you reside with anyone registered at this Practice: Yes No  If so give details: .......................................................................................................................................  |
| **Carer’s**  |
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|  |  |  |
| --- | --- | --- |
|   | No  |   |

Are you a carer Yes  Name & Date of Birth of the person/person’s you care for, if they are registered at this Practice: ..................................................................................................................................................................

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 Are you being cared for? Yes No  Please state the name & address of your carer.................................................................................................................................................................. ..................................................................................................................................................................  |
| **Patient’s Health Style Questionnaire**  |
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 **Smoking Status**: Never Smoked   Stopped Smoking When?....................................................

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 Smoker How many a day?...................................  How many years?...................................  **Alcohol Consumption**: E.g. ½ pint of beer = 1-unit 125ml Glass of wine = 1 unit  Drinks Alcohol Yes How many units do you drink per week?............................................

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|   |

 No

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|   |

Lifetime Teetotaller Yes

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|   |

 No  **Height**: ................................................................ **Weight:** ...........................................................   |
|   Please remember that all sections of this form need to be completed. If registering any children aged 5 and under, you will need to bring in their ‘Red Book/Child Health Record’ or a complete copy of previous immunisations (you can obtain a copy of this from your previous G.P Practice) before the registration can be processed.    |