LEYBURN MEDICAL PRACTICE - NEW PATIENT REGISTRATION

* **FORMS MUST BE COMPLETED PRIOR TO YOUR APPOINTMENT OR YOU MAY HAVE TO MAKE ANOTHER**
* **IF YOU ARE ON ANY REPEAT MEDICATION PLEASE BRING YOUR REPEAT SLIP WITH YOU AND ENSURE YOU HAVE GOT AT LEAST TWO WEEKS’ MEDICATION FROM YOUR PREVIOUS GP.**

New patients will be asked to produce documentation to prove personal and residential identification when registering. Ideally this should be by way of photo ID e.g. passport or driving licence. If you do not have any photo ID then two of the following should be presented:

Birth Certificate Marriage Certificate Driving Licence (old type)

Local Authority Rent Card PAID Utility Bills Bank Card / Financial Statement

National Insurance Number Card

If you do not produce any documentation at the time of registration you will be asked to produce it on your next visit to the surgery. If you fail to produce documentation we may be unable to register you. We apologise for any inconvenience this may cause but we need to do this to prevent fraudulent registrations and prescription fraud.

**Name …………………………………………... Date of Birth ………………………………..**

**Emergency Contact No …………………….. Mobile No …………………………………...**

**Name of Next of Kin and relationship to you .……………………………………………………………**

I am happy for you to send any correspondence to my registered address

I am happy for you to text any test results and messages to the above mobile number

**Ethnic Group (please tick relevant box)**

**White**

British Irish Any other white background

**Mixed (White and Black)**

Caribbean African White and Asian Any other mixed background

# Asian or Asian British

# Indian Pakistani Bangladeshi Any other Asian background

# Black or Black British

# Caribbean African Any other black background

**Other Ethnic Groups**

Chinese Any other ethnic group

# I do not wish to divulge this information Language …………………………………..

**Lifestyle Questions and Medical History**

Never Smoked …… Ex-smoker …… been stopped …… years Smoker …… how many/day ……

Height ……………… Weight …………….

**Please indicate if you have any of the following conditions or if there is any family history of the following:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Medical Problems** | Yes | **No** | **Family History** |
| Heart Problems |  |  |  |
| Stroke |  |  |  |
| High Blood Pressure |  |  |  |
| Cancer |  |  |  |
| Diabetes |  |  |  |
| Asthma |  |  |  |
| Epilepsy |  |  |  |

**Are you a carer for anyone?** (e.g. husband, wife or family member) …………………………………………………..

**Please list below any medication that you are taking (or ideally provide a current prescription slip):**

…………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

**If you are living in Leyburn please identify a Pharmacy where you would like your prescriptions sending as we can only dispense to patients living outside of Leyburn**

……………………………………………………………………………………………………………………………………………

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 |
| ***There is no need to proceed with the remaining questions if you answer ‘Never’.*** | | | | | | | | |
| 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 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Questions** | **0** | **1** | **2** | **3** | **4** |
| How often in the last year have you found you were not able to stop drinking once you had 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 |

**Information and Communication Needs**

If you have any information or communication needs relating to a disability, impairment, or sensory loss, please detail these, along with how these needs may be met.

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