If you are on regular medication please make an appointment with the practice nurse for a new patient health check.

General Information

Name		**Date of Birth**	
Height		**Weight**	

Smoking status

☐ Never smoked	☐ Current smoker	☐ Ex-smoker Date Stopped: ______________
Ethnic background		
First Language		☐ Interpreter required
Telephone Numbers	Home	
	Work	
	Mobile	
Email address		

Consent for future use of appointment reminder and email messaging. Signed ____________________ Please ensure the practice is kept up-to-date with contact numbers.	Yes ☐ No ☐

Alcohol consumption (1 UNIT = ½ pint of beer or 1 small glass of wine or 1 single spirit)

Teetotal ☐	**Number of units per week** ___________

FAST (alcohol screening test)	**Scoring system**					**Your score**
	0	**1**	**2**	**3**	**4**	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only answer the following questions if the answer above is Never (0), Less than monthly (1) or Monthly (2). Stop here if the answer is Weekly (3) or Daily (4).						
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

KNOWN ALLERGIES With tablets, medicines, powders, injections, inhalers, vaccines, foods, animals, plants or minerals	Drug/Non-Drug	Reaction/Severity

Are you registered disabled?	
Do you hold a living will?	

CURRENT MEDICATION – If you take medicines regularly (including contraception, tablets, cream and inhalers) please attach the right hand side of your prescription to this registration form.

Drug Name	**Strength**	**Dose**	**Frequency**

HAVE YOU EVER SUFFFERED FROM:

☐ Atrial Fibrillation	☐ Absent spleen (Asplenic)
☐ Asthma	☐ COPD (emphysema or chronic bronchitis)
☐ Coronary Heart Disease	☐ Current Kidney disorder
☐ Depression	☐ Diabetes
☐ Epilepsy	☐ High blood pressure
☐ Hypothyroidism	☐ Osteoporosis
☐ Serious mental health problem	☐ Stroke / CVA / TIA

Please list any significant illness, operations, accidents and/or disabilities

MEDICAL HISTORY IN IMMEDIATE RELATIVES UNDER 65 YEARS OF AGE

	Please specify relationship	Age the relation contracted this
☐ Heart Disease		
☐ Diabetes		
☐ Stroke		
☐ Other (please specify)		

NEXT OF KIN

Name	
Phone number	
Address	
Relationship to you	

A carer is someone, who, without payment, provides help and support to a partner, child, relative, friend or neighbour, who could not manage without their help.

Are you a carer?	YES / NO If yes please specify …………………………..
Do you have a carer?	YES / NO If yes please specify …………………………..