Marylebone Health Centre New Patient Registration Form (Adult: 16 and over)

1. Complete a separate form for each family member to be registered
2. Complete in BLOCK CAPITALS and tick the boxes as appropriate

1	**Full Name:**				**Date of Birth:** **Your Marital Status:**	
	Title : ☐ **Mr**	☐ **Mrs**	☐ **Miss**	☐ **Ms**	**Gender:** ☐ **Male** ☐ **Female** ☐ **Other.** *Please state* **:**	
	Other. *Please state* **:** **Your maiden name if you are married:**				**Marital Status:** ☐ **Married** ☐ **Single** ☐ **living with partner**	
	Your Mobile tel. number: ***We will use this to send appointment reminders and invitations. Please tick here if you GIVE CONSENT for this:*** ☐				**Your E-mail address:** **We will send your news updates/information about our surgery and your health , If you wish to receive EMAILS FROM US TICK THE CONSENT BOX BELOW** ☐	
	Work tel. number:				**How would you prefer us to contact you:** ☐ **Letter** ☐ **Email** ☐ **SMS (text)** ☐ **Phone**	
	Name of next of Kin: **Relationship to Patient:** **Next of Kin contact tel. number:**					
	Town* and Country of birth (*If town is London please state which Borough) **Country:** **Town:**				**Borough (*If London):**	
	Please list other residents of your home who are registered with us:		**Name:**		**Date of Birth:**	

2.	**Are you looking after someone?** Let us know if you are looking after someone who is ill, frail, disabled or has mental health and/or emotional support needs, or substance misuse problems. If yes you may be a carer	☐ Yes ☐ No
	Is someone looking after you? Let us know if a family member, friend or neighbour looks after you. If yes, they are your carer. You are welcome to invite your carer to accompany you to visits at the practice.	☐ Yes ☐ No
	Your Carer's name : **Are they are keyholder?**	**Relationship to you:** **Do they live with you?**
	Telephone number of carer :	

3. If returning from the Armed Forces please state which below:

☐ **Army**
☐ **Royal Navy**
☐ **Royal Air force**

4 **Are You Currently Employed?**

If so please specify whether :	☐ **Full-time**	☐ **Part-time**	☐ **Self-employed**

If you are not employed, please indicate which best describes you:

☐ **Retired**	☐ **Student**	☐ **Housewife/ Homemaker/House husband**	☐ **Unemployed**

☐ **Other *Please state*:**

5 **Your Religion** (please state)**:**
It's important to let us know if your religion will affect any treatment you receive

Your Ethnic Origin (Please tick one)

☐ Black Caribbean/British	☐ Indian / British Indian	☐ Arabic	☐ White (UK)
☐ Black African /British	☐ Pakistani / British Pakistani	☐ Chinese	☐ White (Irish)
☐ Other Black Background	☐ Bangladeshi / British Bangladeshi	☐ Other	☐ White (Other)
☐ Other Mixed Background	☐ Other Asian Background		☐ Ethnic Category Refused

Do you need an Interpreter? ☐ Yes ☐ No **If yes**, which language:

Do you need help with mobility/hearing/speaking? (tick all that apply)

☐ Wheelchair	☐ Walking aid	☐ Hearing aid	☐ British sign language (BSL)	☐ Makaton sign language
☐ Lip reading	☐ Large print	☐ Braille	☐ Other, Please state:	
Are you currently?	☐ Homeless	☐ A Refugee	☐ An Asylum Seeker	

Are you an 'Assistance Dog' User?	☐ Yes ☐ No
Are you housebound?	☐ Yes ☐ No

6 **Lifestyle**

Are you currently a smoker?	☐ Yes	☐ No	If you smoke, how many Cigarettes / Cigars / Tobacco do you smoke in a day?
Have you ever been a smoker?	☐ Yes	☐ No	

If you are a smoker and want to STOP please tick here: ☐

7

Diet and Exercise	**What type of diet do you have?**
How much exercise do you do?	☐ Healthy
☐ Sedentary (No exercise)	☐ Unhealthy
☐ Gentle (climbs stairs, walking , gardening)	☐ Vegan
☐ Moderate (Cycling, swimming regularly)	☐ Vegetarian
☐ Vigorous (Attends gym regularly)	☐ Moderate

Please enter your height in		**Please enter your weight in**	
Feet / inches:	**cm:**	**Kilos/grams:**	**Stones / lbs:**

8	**Women Only**	What is the date of your last ***Smear test***?	Date:	Result:
	Was this at your GP Surgery?	☐ Yes ☐ No	Date of last ***Mammogram*** (if applicable):	
	Number of ***pregnancies*** (include miscarriages & terminations) (If applicable)			
	Do you wish to see a doctor in this Practice for contraceptive services (including the pill, coil or cap)?			☐ Yes ☐ No

9	**Your Medical Background** Are there any serious diseases that affect **YOU** or **WHO** if your parents, brothers or sisters? If you know date of diagnosis please provide.				
	☐ **Diabetes** YOU; Who:	☐ **Asthma** You: Who:	☐ **Thyroid disorder** You: Who:	☐ **Stroke** YOU: Who:	☐ **COPD** YOU: Who:
	☐ **Heart Attack under age of 60** YOU: Who:	☐ **Cancer (Specify type)** YOU: Who:	☐ **High Blood pressure** YOU: Who:	**Any other important family illness. *Please state*:**	Who:
	Please state any allergies and sensitivities you have to medicines, food & dressings:			Can you use gelatine based capsules: ☐ Yes ☐ No	
	Please state any mental disabilities you have:				
	Are you able to administer your own medicines?	☐ Yes ☐ No	***If no*** please give details, e.g. swallowing or opening containers:		
	What operations or serious injuries have you had?			Date of operations or injuries:	
	Please list any tablets, medicines or other treatments you are currently taking/having?:				
	We can now send your prescriptions electronically to the pharmacy of your choice. If you would like us to do this, please give the name and location of the pharmacy here:				

10	**Sharing Your Medical Record**
	Medical Record Sharing allows your complete GP medical record to be made available to authorised healthcare professionals involved in your care. You will always be asked your permission before anybody looks at your shared medical record. **If you don't want to share your GP record tick here: :** ☐
	Summary Care Record (SCR) contains details of your key health information – medications, allergies and adverse reactions. They are accessible to authorised healthcare staff in A&E Departments throughout England. You will always be asked your permission before anybody looks at your Summary Care Record. You can also enhance the level of information they see. **I do not wish to have a SCR:** ☐ **I wish to have additional data added to my SCR:** ☐
	The Care.data/Integrated care Programme Collates information about you & the care you receive from all NHS services such as your GP & community services, to help them provide a fuller picture of your medical needs and care received. This data maybe made available to NHS Commissioners so that they can design integrated services. **I wish to OPT OUT from my Personal Confidential Data being shared outside my *GP practice*:** ☐ **I wish to OPT OUT from my Personal Confidential Data being shared with *third parties*:** ☐

	The Practice is committed to improving the services we provide to our patients. To do this, it is vital that we hear from people about their experiences, views, and ideas for making services better. By expressing your interest, you will be helping us to plan ways of involving patients that suit you. It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice. If you are interested in getting involved in the Patient Partnership Group, please tick yes in the box below and we will contact you with further details. ***Yes*** **I am interested in becoming involved in the PPG** ☐

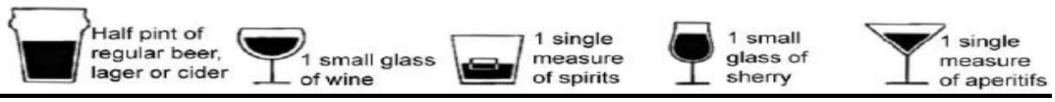
12	**Online Services**	
	You can now do the following online or via the SystmOnline app: • Book and cancel appointments, order repeat prescriptions, view a summary of your medical record. **IT WILL BE YOUR RESPONSIBILITY TO KEEP YOUR LOGIN DETAILS AND PASSWORD SAFE AND SECURE. IF YOU KNOW OR SUSPECT THAT YOUR RECORD HAS BEEN ACCESSED BY SOMEONE THAT YOU HAVE NOT AGREED SHOULD SEE IT, THEN YOU SHOULD CHANGE YOUR PASSWORD IMMEDIATELY**.	
	Yes I'd like to register for online services ☐	***No*** I don't want to register for online services ☐

13	**Other Information**		
	Do you have a "***Living Will***"? (A statement explaining what medical treatment you would not want in the future)?	☐Yes ☐No	***If "Yes",*** can you please bring a written copy of it to your first appointment?
	Have you nominated someone to speak on your behalf (***e.g. a person who has Power of Attorney***)? ☐Yes ☐No	***If "Yes", please state*** their Name: Address: Phone number:	

	Patient signature or on behalf of the patient:	***All patients who register with us will be allocated a named GP. You can find out who your named GP by asking at reception. You can see any GP at the surgery of your choice and if you would like to change the name of your allocated GP let reception know.***

For more information about the services we offer, please refer to our practice leaflet or see our website:
www.marylebonehealthcentre.co.uk

This is one unit of alcohol...



...and each of these is more than one unit

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
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	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

Score from AUDIT- C (other side)

Remaining AUDIT questions

Questions	Scoring system					Your score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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 needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after 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	
Have you or somebody 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 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	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 Higher risk, 20+ Possible dependence

TOTAL Score equals
AUDIT C Score (above) +
Score of remaining questions