**Garden City Surgery**

**57-59 Station Road**

**Letchworth Garden City**

**SG6 3BJ**

**REGISTRATION FORM**

**PLEASE COMPLETE IN BLACK INK & IN CAPITALS**

Surname: ……………………………………………………….. First Names: ………………………………………….

Home Tel: ***(Landline only)*** …………………………………………. Work Tel: ………………………………………………

Mobile Tel: ……………………………………………………….. Email: ……………………………………………………

Preferred contact method: Letter/Email/SMS (*circle as required*)

Do you have any information or communication needs? Yes/No

If you have selected yes, how can we meet your needs?.......................................................................................

**Consent to use mobile number for text alerts:**  *(please tick if you consent)* (XaQid)

Marital Status: Single  Married  Divorced  Widowed 

Occupation: ……………………………………..

What is your Nominated Pharmacy? (*Name & Address*) …………………………………………………………………………

 …………………..……………………………………………………………………….

**First Language:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| English |  | Gujarati |  | Punjabi  |  |
| Polish |  | Hebrew |  | Sinhala |  |
| Bengali & Sylheti |  | Hindi |  | Somali |  |
| Spanish |  | Portuguese |  | Tamil |  |
| British Signing Language |  | Italian |  | Swahili |  |
| Cantonese |  | Japanese |  | Swedish |  |
| Cantonese & Vietnamese |  | Korean |  | German |  |
| Creole |  | Kurdish |  | Tagalog (Filipino) |  |
| Dutch |  | Greek |  | Turkish |  |
| Urdu |  |  |  | Other (*please state*) |  |
|  |  |  |  |  |  |

Are you a carer? Do you look after someone who relies on you for support? Yes / No

Who do you care for? …………………………………

Do you have a carer? Yes / No Carer’s name: …………………………………………….

Carer’s Address: ………………………………………………………………………………………………………………

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

 ……………………………………… Contact No: …………………………………………………

Patient’s Next of Kin …………………………………………………………………………………………….

Their relationship to you ………………………………………………………….

Their Address: ………………………………………………………………………………………………………………

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

 Contact No: …………………………………………………

**Medical History: (We require full access to your records and also permission to share your records with other health care providers under the NHS umbrella to be able to provide you with our services).**

Do you have any current medical problems? Yes / No

Details: ………………………………………………………………………………………………………………………………….

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

Are you taking any medication? Yes / No

**If yes, please provide a copy of your repeat list.**

Do you have any allergies? Yes / No

Details: ……………………………………………………………………………………………………………………………………..............................................................................................................................................................................

Height: ………………………………………………………….. Weight: ………………………………………………………

**Family History:**

|  |  |  |
| --- | --- | --- |
| **DISEASE/ILLNESS** | **RELATION** | **DETAILS** |
| Heart Attack |  |  |
| Stroke |  |  |
| Diabetes |  |  |
| Mental Illness |  |  |
| High Blood Pressure |  |  |
| Asthma/Eczema |  |  |
| Cancer |  |  |
| Epilepsy/Fits |  |  |

**Smoking:**

Have you ever smoked? Yes / No Do you still smoke? Yes / No

 How many do you smoke a day? ……………………

When did you give up: ………………………….. Would you like help to stop? Yes / No

**Alcohol:** Please tick the answer which best applies.

**1 drink = ½ pint of beer or 1 glass of wine or 1 single spirit**

1How often do you have a drink containing Alcohol?

 NEVER MONTHLY 2-4 TIMES 2-3 TIMES 4 OR MORE TIMES

 OR LESS A MONTH A WEEK A WEEK

   ⁫ ⁫ ⁫

2How many units of alcohol do you drink on a typical day when you are drinking?

 1 - 2 3 - 4 5 - 6 7 - 9 10 OR MORE

   ⁫ ⁫ ⁫

3 **Men:** How often do you have 8 or more drinks on one occasion?

 **Women:** How often do you have 6 or more drinks on one occasion?

 NEVER LESS THAN MONTHLY WEEKLY DAILY OR

 MONTHLY ALMOST DAILY

   ⁫ ⁫ ⁫

**OFFICE USE ONLY: TOTAL POINT SCORE : \_\_\_\_\_\_\_\_/**12

**Exercise:**

Do you take regular exercise? Yes / No

If yes, what sort of exercise? …………………………………………………………………………………………………….

How many times per week? ……………………………………………………………………………………………………

By signing below, you consent to share your record in to the practice’s IT systems and out to other NHS Healthcare providers.

Signed: ………………………………………………………… **Thank you for completing this questionnaire.**

**OFFICE USE ONLY:**

|  |  |
| --- | --- |
|   | **DATA ENTERED** |
| Nominated Pharmacy | YES / NO | Removed asOut of Area |  |
| Preferred method communication |   |
| Consent to text - XaQid |  |
| NOK information |   |
| Ethnicity |   |
| First language |   |
| Information or communication needs |  |
| Is a Carer |   |
| Has a Carer |   |
| Smoking status template |  |
| Alcohol |   |
| Allocated GP |   |
| Named GP |   |
| SCR informed dissent |   |
| Registration Completed by & date |  |
| Registration Checked by & date |   |