*****THIS FORM MUST BE COMPLETED IN FULL WHEN REGISTERING*****

Medlock Medical Practice

New Patient Registration Form

Today's Date:

Please complete in BLOCK CAPITALS and tick the boxes as appropriate.

PLEASE BE ASSURED THAT ALL INFORMATION IN THIS FORM WILL BE TREATED CONFIDENTIALLY AND USED IN LINE WITH GDPR REGULATIONS

Mr / Mrs / Miss / Ms / Mx	
Full Name	
Address and Postcode	
Telephone Number	
Mobile Number	
Email Address	
Date of Birth	
NHS Number (If Known)	
Previous / Mother's surname if different	
Place of birth	
****Next of Kin**	
****Next of Kin Contact Number**	
****Are you an asylum seeker?**	Yes ☐ No ☐

Which of the following options best describes your gender?	**Which of the following options best describes your sexuality?**
Female ☐	Heterosexual/Straight ☐
Male ☐	Lesbian/Gay ☐
Non-binary ☐	Bisexual ☐
Transgender ☐	In another way (please state):_____
Intersex ☐	
Is your gender identity the same as the gender you were given at birth?	Yes ☐ No ☐

Would you like to access a free New Patient check at the practice?	Yes ☐ No ☐

Your height	Feet / inches	cm	**Your weight**	Stones / lbs.	kg

****Your Religion:**	Catholic	C of E	Buddhist
	Hindu	Muslim	Sikh
	Jewish	Jehovah's Witness	Other religion (state)/ No religion

****Your Ethnic Origin: (select one)**	White (UK)	White (Irish)	White (Other)
Caribbean	African	Asian	Other Mixed Background
Indian / Brit Indian	Pakistani / Brit Pakistani	Bangladeshi / Brit Bangladeshi	Other Asian Background
Other Black Background	Chinese	Other	Ethnic Category not stated

****Your main or 1st language Spoken / Understood: (select one)**		English	Hindi	Gujurati	Urdu	**Bengali /Sytheti**	**Punjabi**
Polish	Ukrainian	French	German	Spanish	Other: (Please Specify)		

Smoking, Alcohol Consumption and Exercise:

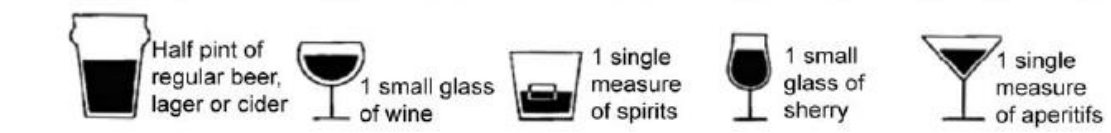
****Are you currently a smoker?**	Yes	No	**Have you ever been a smoker?**	Yes	No
If so, how many cigarettes / cigars / tobacco do you smoke in a day?			*If you are a smoker and want to stop, please ask for information about local smoking cessation services.*		
How often do you exercise?		No. times per week	**Type(s) of exercise:**		

Are there any serious diseases that affect your Parents, Brothers or Sisters (tick all that apply)	Diabetes	Heart Attack	Heart attack under age of 60	Bowel Cancer	
	Breast Cancer		High Blood Pressure	Asthma	Stroke
	Thyroid Disorder		Any other important Family Illness?		

Accessible Information Standards	
Please tick any of the listed methods of contact that you DO NOT wish for us to use	Phone ☐ Email ☐ SMS ☐ Letter ☐
Do you require to receive the information in any specific format	Large print ☐ Audio ☐ Braille ☐ Easy Read ☐
Do you require any communication support for your appointments?	BSL ☐ Interpreter ☐ Lip-Reading ☐ Hearing Aids ☐
Are you an 'Assistance Dog' User?	Yes ☐ No ☐

Are you a military veteran? (Please circle as appropriate)	Yes ☐ No ☐ If yes do we have your consent to record this on your records? Y/N
****If you are a Carer, please state the name / address / phone number of the person you care for:**	**Person Cared For Contact Details:**
If you have a Carer, please state their name / address / phone number and sign here if you wish us to disclose information about your health to your Carer.	**Carer Contact Details:**

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.

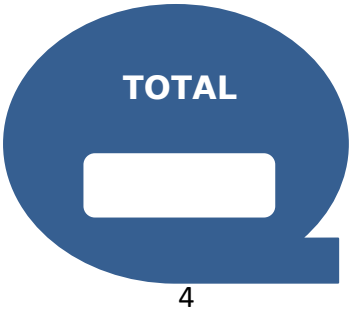
Score from AUDIT- C (other side)

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



Summary Care Records - *This information is not available to anyone else and is only viewable by NHS services.*

The NHS are changing the way your health information is stored and managed.
The NHS Summary Care record is an electronic record of important information about your health that will be available to other services such as A&E and BARDOC. You may tick the 'allow additional information to be viewed' which will allow things like language spoken, serious health issues, etc to be shared with these services.

****Are you happy to have a Summary Care Record?**	**Yes**	**Yes and allow additional information to be viewed**	**No**

Patient Participation Group

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, please tick the box below and we will arrange for the Practice Patient Participation Group Application Form to be given to you at your initial consultation.

Yes, I am interested in becoming involved in the Practice Patient Participation Group (Please tick the "Yes" Box)	**Yes**

Patient Name:		**Date Of Birth:**	

Email Address:

Patient Signature:		**Signature on behalf of Patient:**	

Thank you for completing this form