Riley House Surgery
PRIVATE & CONFIDENTIAL

New Patient Registration Form - ADULT

PATIENT DETAILS

SURNAME:..... FIRSTNAME:.....

DATE OF BIRTH:..... SEX: (Please circle) MALE / FEMALE

ADDRESS:.....

POSTCODE:..... HOME PHONE No:.....

MOBILE PHONE No:..... WORK PHONE No:.....

☐ **There may be occasions when practice staff need to leave a message on your telephone, please tick this box only if you <u>do not</u> want us to leave a message on your telephone**

NHS NUMBER:..... MARITAL STATUS:.....

PREVIOUS ADDRESS:.....

OCCUPATION:.....

COUNTRY OF BIRTH:..... LANGUAGE SPOKEN:.....

PREVIOUS GP NAME:.....

PREVIOUS PRACTICE NAME/ADDRESS:.....

PREVIOUS HEALTH AUTHORITY(IF KNOWN):.....

EMERGENCY CONTACT NAME:.....

EMERGENCY CONTACT NUMBER:.....

EMERGENCY CONTACT RELATIONSHIP:.....

DO YOU LOOK AFTER SOMEONE? (Please circle) YES / NO

DOES SOMEONE LOOK AFTER YOU? (Please circle) YES / NO

HOW MANY CHILDREN DO YOU HAVE?.....

ETHNICITY *(Please tick ☑ a box)*

White British		Asian/Asian-British-Indian	
White Irish		Asian/Asian-British-Pakistani	
Greek Cypriot		Asian/Asian-British-Bangladeshi	
Turkish Cypriot		Asian/Asian-British-East African	
Kurdish		Asian/Asian-British-Other	
Turkish		Black/Black British-Caribbean	
White Other		Black/Black British-African	
Mixed White & Black Caribbean		Black/Black British-Other	
Mixed White & Black African		Chinese	
Mixed White & Asian		Any other ethnic group	
Mixed Other		I decline to give my ethnicity	

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PATIENT STATS

Approx Height: …… Approx Weight: ……

BP (Systolic): …… BP (Diastolic) ……

LIFESTYLE

SMOKING STATUS

I have never smoked ☐

I am currently a smoker ☐

How many do you smoke a day? ……

I would like more information on giving up smoking ☐

I have given up smoking ☐

I quit smoking on (Date) _ _ / _ _ / _ _ _ _

EXERCISE STATUS

Enjoys light exercise ☐ Enjoys moderate exercise ☐

Enjoys heavy exercise ☐ Exercise physically impossible ☐

DRINKING STATUS

I do not drink alcohol at all ☐ Light drinker – 1-2u/day ☐

Moderate drinker – 3-6u/day ☐ Heavy drinker – 7+ u/day ☐

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

How many standard alcoholic drinks do you have on a typical day when you are drinking?

1 – 2	3 - 4	5 - 6	7 - 9	10+

How often do you have 6 or more standard drinks on one occasion?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily

FAMILY HISTORY(Please enter the member of your family with condition, i.e. mother, father, sister, brother)

Asthma: …… CVA/TIA/Stroke: …… Thyroid Disease: ……

CHD: …… Cancer: …… Diabetes: ……

Epilepsy: …… Hypertension: …… Other: ……

FEMALE PATIENTS ONLY

Date of last Cervical Smear (done in UK): …… Result: ……

Are you taking Contraceptives? YES / NO If yes what type & name……

Have you ever had a mammogram? YES / NO If yes what was the date?……

Was the Mammogram normal? YES / NO

Was any further investigation or treatment required? YES / NO