

**MARKET HARBOROUGH MEDICAL CENTRE  
New Patient Registration Questionnaire**

Welcome to Market Harborough Medical Centre. Please help us to help you by filling in this questionnaire in as much detail as possible, as it can take several weeks for your medical records to reach us. The information you give will be treated in strict confidence and will help us provide you with appropriate medical care.

**Please note, we cannot register you until we have received a fully completed questionnaire.**

If you are 45 or over and would like a new patient check please make an appointment with reception. The enclosed Practice Booklet will give you more information on this.

**IF YOU HAVE CHILDREN UNDER THE AGE OF 5 PLEASE ONLY COMPLETE QUESTIONS 1 TO 5 FOR THEM.**

**1. Personal details or details of dependents you are completing this form for:**

DATE : ..... DATE OF BIRTH: .....  
NAME: ..... TITLE (PLEASE SPECIFY) MR/MRS/MISS/MS .....  
ADDRESS: ..... HOME TEL No: .....  
..... MOBILE TEL No: .....  
POSTCODE: ..... OCCUPATION: .....

**2. Next of kin:**

NAME: ..... RELATIONSHIP TO YOU: .....  
ADDRESS: .....  
POSTCODE: ..... CONTACT TEL No: .....

**3. Disabilities:**

Please give details of any disabilities that you have, relating to:

EYESIGHT: ..... HEARING: .....  
MOBILITY: ..... LEARNING: .....

**4. Ethnic Group:**

The Department of Health has asked us to record the ethnic origin of all new patients.  
This information will be added to your medical record.

**If you do not wish to provide this, please tick the Information refused' box at the following list.**

Ethnic Origin (Please tick the description which you feel is most appropriate).			
British or Mixed British		Other Mixed Background	
African		Other White Background	
Bangladeshi or British Bangladeshi		Other	
Caribbean		Pakistani or British Pakistani	
Chinese		White and Asian	
Indian or British Indian		White and Black African	
Irish		White and Black Caribbean	
Other Asian Background		Information Refused	
Other Black Background			

**5. First Language:**

If English is not your first language, please state language spoken: .....

**6. Carers:**

Are you a Carer? (Please give details, including approx. hours per week) .....

***A carer is someone who for 14 hours a week or more is responsible for looking after a relative or friend who, because of disability, illness or old age, cannot manage without help.***

**Please give details of the person you care for:**

NAME: ..... TITLE: (PLEASE SPECIFY) MR/MRS/MISS/MS .....

ADDRESS: ..... HOME TEL No: .....

..... MOBILE TEL No: .....

POSTCODE: ..... RELATIONSHIP: .....

PLEASE INDICATE IN WHAT WAY YOU CARE FOR THIS PERSON:

.....  
.....

## 7. Health:

Please answer the questions relating to any conditions you have:

√	CONDITION	QUESTION
	Asthma or other breathing problem (e.g COPD)	Date of last spirometry test Today's peak flow measurement
	Blood Pressure	
	Cancer	Type of Cancer Date of Diagnosis
	Diabetes	Date of last visit to optician Date of last visit to podiatrist/chiropracist
	Epilepsy	Date of last full daytime seizure (fit) Date of next hospital follow-up appointment
	Heart (angina, previous heart attack etc)	What kind of heart problem do you have?
	Kidney (renal problems)	
	Mental health problems	Name of consultant and/or CPN Do you take Lithium?
	Operations	Please specify any operations you have had
	Stroke/mini stroke	Date of Stroke (s)
	Thyroid (Under or Over Active)	Do you take thyroxine? Date of last blood test
	Allergic reaction (rash, Anaphylactic shock)	What are you allergic to?

Have you ever had a bad allergy or reaction to any medicines? (If so, give details)

.....  
**If you are taking prescribed medication, please make an appointment to see your doctor within two weeks and bring your medicines with you. (We will not be able to issue any repeat prescriptions until you have seen a doctor).**

## 8. Family History:

Have any members of your immediate family (parents, brothers and sisters) had any of the following medical problems?

CONDITION	YES / NO	CONDITION	YES / NO
BREATHING		BLOOD PRESSURE	
CANCER		DIABETES	
HEART		STROKE/MINI STROKE (please specify)	

## 9. Ladies only:

LAST SMEAR (DATE)		LAST SMEAR (RESULT)	
LAST MAMMOGRAM (DATE)		LAST MAMMOGRAM (RESULT)	
METHOD OF CONTRACEPTION			
If you are pregnant please make an appointment to see your doctor as soon as possible, so that the ante-natal care can be arranged for you.			

**10. About your immunisations:** 

Vaccinations – children – (please tick and give dates if known):

VACCINE	AGE 2 MNTHS	AGE 3 MNTHS	AGE 4 MNTHS	AGE 12 MNTHS	AGE 13 MNTHS	AGE 3 – 5 YRS	AGE 10 – 14 YRS	AGE 13 – 18 YRS
Pneumococcal								
Polio (By mouth)								
Hib, DTP								
Meningitis C								
Measles, Mumps, Rubella								
BCG								

Vaccinations – other – (please tick and give dates if known):

VACCINE	DATE	VACCINE	DATE
Pneumonia		Travel – give details	
Tetanus			
Other – give details			

**11. Lifestyle:**

Approximately how much do you weigh? .....

Approximately how tall are you? .....

Do you follow any special diet eg. Vegan, low fat etc? .....

How many cigarettes or ounces of tobacco do you smoke per day? .....



***Giving up smoking is the single most important step that you can take to improve your health. We strongly advise all smokers to quit and are happy to help. Pick up a Smoking Cessation Service card, or speak to your doctor or nurse.***

If you do not smoke, have you ever smoked in the past? .....

If you used to smoke, please state how much and when you quit: .....

What form(s) of exercise do you take (eg walking, swimming etc) .....

How long each time? ..... How many times per week? .....

How many units of alcohol do you drink on average per week? .....

*The recommended safe allowance is 14 units for women and 21 units for men per week.*

Pint of regular Beer/Lager/Cider = **2 units**

Bottle of wine = **9 units**

Alcopop or Can of Lager = **1.5 units**

Single measure of spirits = **1 unit**

Glass of Wine(175ml) = **2 units**

**ONLY APPLICABLE TO PATIENTS AGED 16 OR OVER**

**FAST ALCOHOL SCREENING TEST (FAST)**

QUESTIONS	SCORING SYSTEM					SCORE
	0	1	2	3	4	
On any one occasion how often do you have: <u>Male</u> 8 or more drinks? <u>Female</u> 6 or more drinks?	NEVER	LESS THAN MONTHLY	MONTHLY	WEEKLY	DAILY OR ALMOST DAILY	
<b>ONLY ANSWER THE FOLLOWING QUESTIONS IF YOUR ANSWER ABOVE IS MONTHLY OR MORE</b>						
How often, in the last year, have you not been able to remember what happened when drinking the night before?	NEVER	LESS THAN MONTHLY	MONTHLY	WEEKLY	DAILY OR ALMOST DAILY	
How often, in the last year, have you failed to do what was expected of you because of drinking?	NEVER	LESS THAN MONTHLY	MONTHLY	WEEKLY	DAILY OR ALMOST DAILY	
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	NO		YES, BUT NOT IN THE LAST YEAR		YES, DURING THE LAST YEAR	

TOTAL SCORE:.....

**SCORE 0 – 2 FINISHED**

**IF SCORE IS 3 OR OVER PLEASE GO ON TO COMPLETE THE FINAL PAGE OF QUESTIONS.**

## CONSUMPTION AUDIT

QUESTIONS	SCORING SYSTEM					YOUR SCORE
	0	1	2	3	4	
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	7-8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
How often, in the last year, have you found you were not able to stop drinking once you had started?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
How often, in the last year, have you failed to do what was expected of you because you were drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
How often, in the last year, have you needed an alcoholic drink in the morning to get you going?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
How often, in the last year, have you had a feeling of guilt or regret after drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
How often, in the last year, have you not been able to remember what happened when drinking the night before?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
Have you or someone 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/friend/doctor/ health worker been concerned about your drinking and advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	

TOTAL SCORE:.....

	SENSIBLE DRINKING	HAZARDOUS DRINKING	HARMFUL DRINKING	? DEPENDENCE
SCORE	0-7	8-15	16-19	20+

Admin use only: GP ( ) Computer ( ) Allergy ( ) NPQ Code ( ) Scan ( )