**MEMORIAL MEDICAL CENTRE**

**For Office Use:**

Photo ID €

Proof of residence €

**Staff name**………….

**Date**…………………

**New Patient Registration Questionnaire**

 **Please bring 2 forms of identification**

1. ID (driving license/passport)
2. A letter with proof of address (utility bill, rent agreement, bank

statement, mortgage statement etc).

**\*\*\*We do not accept registrations from anyone living outside**

 **The Practice boundary\*\*\***

**If you are on any regular medication, please bring along the right hand side of your prescription sheet.**

**Date:**

**Name and Address: Date of Birth:**

**Home Telephone Number: Mobile Number:**

**Email Address:**

**What is your preferred method of contact? Email / Landline/ Mobile/ Txt Message / Post**

If opting for txt message or email, please read the information on page 13 of the Practice leaflet.

**Do you consent to the sharing of your Summary Care Record? Yes/No**

(This enables hospitals to view vital areas of your medical history, such as allergies, medication and long term health problems electronically. It is particularly useful in an emergency, when they may not be able to contact us for information)

**Are you a carer? Yes/No**

**Do you have a carer? Yes/No**

**Do you have social services input? Yes/No**

**Are/were you or a member of your immediate family in the Armed Forces?**

**Yes (me) Yes (family member) No**

**Ethnic Origin: (Please tick)**

(Asian or Asian British) Bangladeshi (Asian or Asian British) Indian

(Asian or Asian British) Other Background (Asian or Asian British) Pakistani

(Black or Black British) African (Black or Black British) Caribbean

(Black or Black British) Other Background (Mixed) Other Background

(Mixed) White & Asian (Mixed) White & Black African

(Mixed) White & Black Caribbean (Other) Any other

(Other) Chinese (White) British

(White) Irish (White) Other Background

Not Stated

**Medical History:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Condition** | **Yes/No** | **Date/Year of Diagnosis** | **Additional Info**  |
| Cancer |  |  |  |
| Respiratory (Asthma, COPD etc) |  |  |  |
| Mental Health |  |  |  |
| Learning DisabilityMild difficulties orModerate/severe disability? |  |  | Do you need additional support from the Practice and would you like to be invited for an annual review? Yes/No |
| Diabetes |  |  |  |
| Heart Problems |  |  |  |
| Epilepsy |  |  |  |
| Thyroid Problems |  |  |  |
| Stroke |  |  | Are you on anticoagulants? Yes/No  |
| High Blood Pressure |  |  |  |

**Family History:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Condition** | **Relative** | **Yes/No** | **Age** |
| Asthma |  |  |  |
| Stroke |  |  |  |
| Diabetes |  |  |  |
| Heart attacks under 60 |  |  |  |
| Heart attacks over 60 |  |  |  |

**Please list any drugs you are allergic to:**

**Please list all other regular medications, their strength and dose regimen:**

**Preferred Pharmacy:**

(We will default this to the Memorial Pharmacy if you don’t have a preference)

**PLEASE BRING IN A COPY OF ALL OF YOUR IMUNISATIONS, INCLUDING TRAVEL VACCINATIONS.**

**If female, please answer section below, if male please go to next section:**

Date of last smear: Result:

Have you ever has an abnormal smear?: Yes/No

**Please tick the following that best describes certain aspects of your lifestyle:**

**SMOKING:** Current smoker Amount of cigarettes/tobacco weekly

 Ex Smoker Year you stopped:

 Never smoked tobacco

 **Would you like help giving up smoking? Yes/No**

**ALCOHOL CONSUMPTION:**

**1 unit of alcohol = 1 glass of wine, ½ pint of beer, 1 measure spirit**

1. How often do you have a drink containing alcohol?

🞎 Never 🞎 Monthly or less 🞎 2 to 4 times a month 🞎 2 to 3 times a week

🞎 4 or more per week

1. How many standard drinks containing alcohol do you have on a typical day, when drinking?

🞎 1 or 2 🞎 3 or 4 🞎 5 or 6 🞎 7 to 9 🞎 10 or more

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

🞎 Never 🞎 Less than monthly 🞎 Monthly 🞎 Weekly 🞎 Daily or almost daily