**Office use only**

|  |  |
| --- | --- |
| Pt Informed Named GP | Yes  Usual GP: |
| ID seen for Online Access by |  |
| Routine HC Advise given i.e smears / imms |  |

**WE DO NOT REGISTER CHILDREN UNDER 16 YRS OLD WITHOUT PARENTS / GUARDIAN BEING REGISTARED AT THE PRACTICE**

**Patient Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** |  | | |
| **First Name** |  | | |
| **Surname** |  | | |
| **Date of Birth** |  | Previous GP Name: | |
| **Your NHS** |  | | **If this is your 1st registration with NHS then enter the date came to UK:** |
| **Your Current Address** |  | | |
| **Mobile No** |  | | |
| **Email** |  | | |
| Occupation |  | | |

**Preferred method of communication:**

Consent to receive ***SMS*** Notification for Clinical Service **Y/N**

Consent to receive ***EMAIL*** Notification for Clinical Service **Y/N**

**Carers Information**

Do you look after someone who is ill, frail or disabled? Yes/No

Are you a carer? Yes/No

Do you have a carer? (Does someone look after you?) Yes/No

If yes, please tell us their name and telephone number

What is their relationship to you? 

**Next of Kin**

|  |
| --- |
| Relationship to you:  Title: Name:  Contact No: |

*We would only contact your next of kin in an emergency. We do not divulge confidential information to anyone without your permission.*

***I give consent for the practice to access my medical information from hospitals and previous doctors if necessary for my medical care.***

|  |  |
| --- | --- |
| ***Signature*** | ***Date*** |

**Our GP Online Service**

Would you like to sign up for ***Patient Access*** allowing you to book appointments & order repeat prescriptions on-line? Yes No

Please read the **Do It Online Leaflet** for further information

|  |  |
| --- | --- |
| Do you have any  special needs? | Yes/No If Yes, Please state: |
| Are you registered disabled? | Yes/No |

Medical History

* Do you suffer from any Long term conditions? Y/N
* Have you had any serious illnesses that were treated in hospital? Please give details including dates when possible. For example: Heart attack, Stroke, Cancer.

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  | Other? Please state |
|  |  |  |

**Family Medical History** – Has any family member/s suffered from the following?

|  |
| --- |
|  |

**Medications** – Are you taking any drugs or medicines? Yes/No

**Allergies** – Are you allergic to any medicines Yes/No

If yes, which ones? And what happens if you take them?

|  |
| --- |
|  |

Have you been in hospital with a serious illness/operation?

Exercise – Do you take exercise? If so, what? And how often?

|  |
| --- |
|  |

**Signature of patients Signature on Behalf of Patient**

**- - -- - - - - - - - - -- - - - - - - - - - - - - - - - - - - - - - - - - -**

**Date - - - - - - - - - - - - - - - -**

**Children under 16yrs old**

**Children under 16yrs old – Family contact details**

**At this surgery we feel that it is important to look after the entire family.**

Childs Surname………………………………………………

Childs First Name…………………………………………….

Childs Date of Birth…………………………………………..

Address………………………………………………..

…………………………………………………………..

…………………………………………………………..

Telephone Number……………………………………

Mobile Number………………………………………….

Mothers Name……………………………….Are you registered/registering at the surgery… …………**Y/N**

Fathers Name………………………………..Are you registered/registering at .

the surgery… …………**Y/N**

**If the Mother is not registered/registering please provide reason:- Mother deceased/Mother abroad/Divorced and Father has custody.**

**Other…………………………………………………………………**

Brothers and sisters details (if applicable)

|  |  |  |
| --- | --- | --- |
| Surname | First Name | Date of Birth |
|  |  |  |
|  |  |  |
|  |  |  |

**If you are not the Childs Mother/Father your details and relationship to child.**

Surname………………………………………………..

First Name……………………………………………..

Relationship……………………………………………..

Are you registered/registering at the surgery…………**Y/N**

Please tell us who else lives in your household.

…………………………………………………………..

…………………………………………………………..

**If any of these details change please inform the surgery as soon as possible.**

**Thank you**

**This Form must be completed by children under 16 years of age**

Please complete this form by looking at eh Red immunisation Book or other Immunisations Records

|  |  |  |  |
| --- | --- | --- | --- |
| Childhood Immunisation Details | | | |
| When | Diseases Protected Against | Date given | Place given  *GP or Other* |
| At birth | **BCG** Tuberculosis |  |  |
| 1st Dose  At 8 weeks | **DTaP/IPV/Hib/HepB Diphtheria,** tetanus, pertussis (whooping cough), polio, Haemophilus influenzae type b (Hib) and hepatitis B |  |  |
| **Men B** |  |  |
| **Rotavirus** |  |  |
| **PCV** (Pneumococcal) |  |  |
| 2nd dose  At 12 weeks | **DTaP/IPV/Hib/HepB Diphtheria,** tetanus, pertussis (whooping cough), polio, Haemophilus influenzae type b (Hib) and hepatitis B |  |  |
|  | **Rotavirus** |  |  |
| 3rd Dose  At 16 weeks | **DTaP/IPV/Hib/HepB Diphtheria,** tetanus, pertussis (whooping cough), polio, Haemophilus influenzae type b (Hib) and hepatitis B |  |  |
|  | **Men B** |  |  |
| **PCV** (Pneumococcal) |  |  |
| 12 & 13 months  ( after Birthday) | **MMR**  Measles, mumps and rubella (German measles  **Hib/MenC**  **PCV** (Pneumococcal **Booster)**  **Men B** Booster |  |  |
| 3.1/2 years  (3 yrs from the 3rd dose) | **DTaP/IPV**  tetanus, pertussis (whooping cough), polio  **MMR**  Measles, mumps and rubella (German measles |  |  |
| 14 years old (school year 9) | Td/IPV  Tetanus, diphtheria and polio |  |  |
| Other  Please give details |  |  |  |

**Ethnic Background/Origin**

Please select what you consider your ethnic origin to be. **Ethnicity is not the same as your nationality.** For example, many of our patients whose nationality is British may also be from different ethnic groups such as Irish, Caribbean or Bangladeshi. It is important to us that you describe your own ethnic background/origin.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. **ASIAN OR ASIAN BRITISH** | Please tick as appropriate | **D. MIXED** | Please tick as appropriate | |
| Indian |  | White & Black Caribbean |  | |
| Pakistani |  | White & Black African |  | |
| Bangladeshi |  | White & Asian |  | |
| **Any other Asian background**. Please write in: | | **Any other Mixed background**. Please write in: | | |
| **B. BLACK OR BLACK BRITISH** | Please tick as appropriate | **E. WHITE** | Please tick as appropriate | |
| Caribbean |  | British |  | |
| African |  | Irish |  | |
| **Any other Black background**. Please write in: | | **Any other White background**. Please write in: | | |
| **C. CHINESE OR OTHER ETHNIC GROUP** | Please tick as appropriate | **F. DECLINED** | | Please tick as appropriate |
| Chinese |  | I do not wish to give this information | |  |
| **Any other**. Please write in: | | Please help us to understand why you have chosen not to disclose this information: | | |
| **Main Language.** | | **Interpreter needed YES/NO** | | |

**You are under no obligation to complete this questionnaire**

**Data Protection:** Please be assured that the information you provide will remain anonymous and will only be stored in your medical record held by the practice. All details are held in accordance with the Data Protection Act 1998

**March 2020**