St Peter's Medical Centre

Patient Registration Form

Date:	
Forenames:	Surname:
Address: Postcode: Home Tel No. Mobile No. Email address:	Date of Birth: Weight: Height: I give my consent to receive SMS text notification for clinical services. *(please tick)* Yes [ ] No [ ] I give my consent to receive SMS text notification for events & services available. *(please tick)* Yes [ ] No [ ] I give my consent to receive email notification for clinical services. *(please tick)* Yes [ ] No [ ] I give my consent to receive email notification for events & services available. *(please tick)* Yes [ ] No [ ]
Online Patient Participation Representation Group Would you like to be part of our online patient participation group and receive the electronic newsletter? *(please tick)* Yes [ ] No [ ]	Next of Kin: Relationship: Contact Tel No:
Name of School (if aged between 6-16yrs):	

1) Have you suffered from or with any of the following:

Heart Attack	Diabetes	Cancer
High Blood Pressure	Asthma	Stroke or TIA
Mental illness	COPD	

If you suffer from any of the above illness, please provide details below:

2 a) Have you had any illness or operations in the past*? (please tick)* Yes [ ] No [ ]

b) Have you been previously tested or treated in the UK for TB? *(please tick)* Yes [ ] No [ ]

c) Have you ever lived for more than 6 months in a country with high incidence for TB? *(please tick)* Yes [ ] No [ ]

If unsure name the country(s) where you have lived.

3) Do you smoke? *(please tick)* Yes [ ] No [ ]

If YES, how many per day? Cigarettes: Cigars: Pipe:

When did you start smoking? Start date: ……

If you are an ex-smoker, when did you stop smoking? Stop date: ……..

4) Do you drink Alcohol? *(please tick)* Yes [ ] No [ ] Occasionally [ ]

If Yes or occasionally, how many units per week?

Beer: Wine: Spirits:

(1 unit= half pint beer/cider or 1 glass sherry/vermouth or 1 glass of wine or single measure of gin/whisky/rum/vodka)

5) Do you consider yourself having any form of disability? if so please state below.

On the basis of your answer, is there anything the practice could do to help you access health care services here? (ie: BSL interpreter)

6) Are there any medicines or drugs that have disagreed with you or to which you are allergic?

(if so please list the drug and your reaction below)

Any other allergies:

7) Please state all prescribed medicine that you are currently taking below:

8) How often do you exercise per week?

[ ] once a week [ ] 3 times or more [ ] everyday

FOR ALL PATIENTS

FAMILY MEDICAL HISTORY

9) Have any of your close relatives suffered from any of the following illnesses?

If so please state which relative(s) next to the medication condition.

Heart Attack	
Heart Disease	
Diabetes	
Stroke or TIA	
Asthma	
High Blood Pressure	
Mental Illness	
Eczema	
Epilepsy or fits	
Cancer of any type (please specify type)	

Please specify below if any relative(s) suffer from any other serious illness not mentioned above.

10-a) Are you are carer for an elderly or sick relative or friend? *(please tick)* Yes [ ] No [ ]

If yes, please indicate your relationship:

b) Do you have a carer? *(please tick)* Yes [ ] No [ ]

If yes, please indicate your relationship:

FEMALES ONLY

11) Do you have regular cervical smears taken? (Please state if you have never had a smear taken)

a) When did you last have a cervical smear?

b) Where was the test taken?

c) What was the result?

12) Do you currently use contraception? If so, what form are you on?

a) If you are currently on the pill when did you last have your blood pressure taken?

Patients aged 6 -20 Only

Have you received the MMR vaccination? If so, please submit dates of:

Dose 1:

Does 2:

Patient Profiling Questions

Section A. Communication and Language Support

1. Do you need support with Spoken English? Yes [ ] No [ ] Interpreter needed (including BSL,) [ ]

Please state which language?

2. Do you need support with written English? Yes [ ] No [ ] Large Print [ ]

[ ] Translated Materials, please state which languages:

3. Is English your first Language? Yes [ ] No [ ] (please state your first language:

Section B. Communication and language support

4. Which religion do you follow or practice?

[ ] Buddhism [ ] Christianity [ ] Islam [ ] Hinduism [ ] Judaism

[ ] Jehovah's Witness [ ] Sikhism [ ] any other religion, please state:

[ ] I do not wish to answer

5. To which of these ethnic groups do you feel you belong?

White

[ ] British

[ ] Irish

[ ] English

[ ] Welsh

[ ] Scottish

[ ] Polish

[ ] Romanian

[ ] Any other White Background

Please write in:

Chinese or other ethnic Group

[ ] Chinese

[ ] Vietnamese

[ ] Japanese

[ ] Filipino

[ ] Latin American

[ ] Arab

[ ] Moroccan

[ ] North African

[ ] Iranian

[ ] Kurdish

Black or Black British

[ ] Black Caribbean

[ ] Black African

[ ] Black British

[ ] Any other Black background,

Please write in:

[ ] any other, please write in:

Mixed

[ ] White & Black Caribbean

[ ] White & Black African

[ ] White & Asian

[ ] Black & Asian

[ ] Black & Chinese

[ ] Chinese & White

[ ] Any other Mixed Background

Asian or Asian British or Mixed

[ ] Indian/British Indian

[ ] Pakistan/British Pakistan

[ ] Bangladesh/British Bangladesh

[ ] East African Asian

[ ] Sri Lankan

[ ] Tamil

[ ] Any other Asian Background

I do not wish to answer [ ]

Consent Form

Patient Name: _____

Date of Birth: _____

Address: _____

_____

I give permission for the following person/s:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

To be able to do the following on my behalf at St Peter's Medical Centre:

☐ Book appointments ☐ Cancel appointments

☐ Request prescriptions ☐ Collect prescriptions

☐ Surgery to leave messages with this person relating to myself

☐ Check test results

Other, *Please specify*: _____

_____

A copy of this document will be added to the patients' Medical records

Please be aware that you have the right to withdraw this consent at any time.

Also, please inform the surgery of any amendments to the above information.

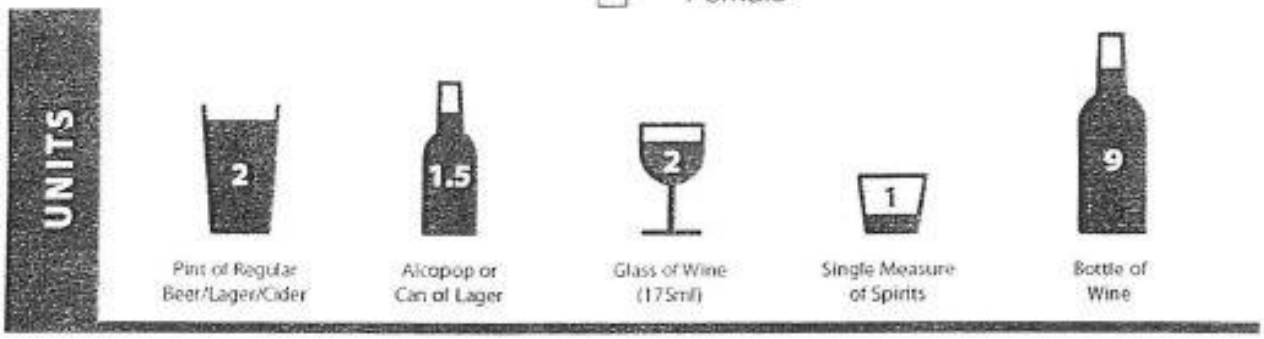
Patient Signature: _____

Date: _____

Fast Alcohol Screening Test (FAST) and Alcohol Users Disorders Identification Test (AUDIT)

Name *(please print)*: _____

Date of Birth: _____ ☐ Male ☐ Female



	Questions	Scoring System 0	1	2	3	4	Your Score
1	How often do you have 8 (men) or 6 (women) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
2	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	
3	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	
4	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	
	Please add your score for questions 1 – 4						
	If your score so far comes to 3 or more please continue with the questionnaire, if it is 2 or less please stop						
5	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	
6	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+	
7	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	
8	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	
9	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	
10	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	
	Please add your score for questions 1 – 10						