## Rowan Tree PrActice

# REGISTRATION FORM

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| Today’s date: |  |
| PATIENT INFORMATION |
| Patient’s last name: | First: | Middle: | ❑ Mr.❑ Mrs. | ❑ Miss❑ Ms. | Marital status (circle one) |
|  | Single / Mar / Div / Sep / Wid |
| Other Names if any: |  |  | Birth date: | Age: | Sex: |
|  |  |  |  / / |  | ❑ M | ❑ F |
| Street address: | City/Town: | County: |
|  |  |  |
| Post Code: | Email Address: | Home No: | Mobile No: |
|  |  |  |  |
| Previous Doctor details: | Previous address (if current is less than 3 years): | NHS Number (if known): |
|  |  |  |
| Chose surgery because referred to by (please check one box):  |
| Dr ❑ ❑ Family ❑ Friend ❑ Close to home/work ❑ Internet ❑Other |
| Other family members seen here: |  |
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| IN CASE OF EMERGENCY |
| Next of Kin:- contact name and details: | Relationship to patient: | Home phone  | Mobile No: |
|  |  |  |  |
| The above information is true and accurate to the best of my knowledge. |
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|  | Patient/Guardian signature |  | Date |  |

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| Ethnic Category |
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| --- | --- | --- |
| White ❑  | White Irish ❑  | Other ❑ |
| Mixed ❑  | W&B Caribbean ❑  | W&B African ❑  |
| White & Asian ❑ | Asian Indian ❑ | Asian Pakistani ❑ |
| Asian Bangladeshi ❑ | Other Asian ❑ | Black Caribbean ❑ |
| Black African ❑ | Other Black ❑ | Other Ethnic ❑ |

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| PATIENT Medical INFORMATION |
| Height Weight BP (if known) |
| Are you currently a smoker? | ❑ Yes ❑ No |
| If so how many cigarettes/tobacco do you smoke per week: |  |
| Have you ever been a smoker? | ❑ Yes ❑ No |
| Do you drink alcohol? | ❑ Yes ❑ No |
| If yes – please complete the attached alcohol consumption questionnaire  | Completed ❑ Yes ❑ No |
| Have you suffered from any of the following conditions:

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| --- | --- | --- |
| Diabetes ❑  | Asthma ❑  | COPD ❑ |
| Hypertension ❑  | Heart Disease ❑  | Stroke ❑  |
| Epilepsy ❑ | Thyroid Disease ❑ | Cancer ❑ |
| Depression ❑ | Other Mental Illness ❑ | Other ❑ |

If you have any of these conditions please make a review appointment when you register |
| Have you ever had any other significant illnesses, if so when? |  |
| Have you ever had any operations, if so when? |  |
| Do you have any medical problems at present? |  |
| Please state any allergies or sensitivities you have: |  |
| Please list any tablets or medicines currently being taken: |  |
| **PATIENT MEDICAL INFORMATION** |
| Are you able to administer your own medicines ❑ Yes ❑ No If No please detail specific issues (e.g. difficulty in swallowing or opening bottles etc.) |
| Please state any sensory impairment you have (i.e. Speech, Hearing, Sight, Other). Please give details: |
| Please state any disabilities you would like us to be aware of |
| Do you require the assistance of a Translator/Interpreter? | Yes | No |
| Which language do you speak? |  |
| If you have a Carer, please state their Name/Address/Phone number:Sign here if you wish us to disclose information about your health to your Carer:-**Signed: Date:**  |
| Do you have a “living will”? ❑ Yes ❑ NoIf Yes – can you please bring a written copy of it to your New Patient Consultation |
| Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)  ❑ Yes ❑ NoIf Yes, please state their Name/Address/Phone number: |
| If you are on repeat medication please make an appointment with your Doctor to discuss your current prescription needs.❑ Yes ❑ No **DATE OF APPOINTMENT:** |
| Would you like to register for Patient Access to book appointments online? ❑ Yes ❑ No   |
| Would you like to nominate a preferred Pharmacist for Electronic Prescription Service please provide details below:- |
| Women Only |
| Date of last mammogram(if over 50 or under regular surveillance): | Date: |  |
| Have you had a Hysterectomy? | Yes | No | Date |
| Method of contraception |  |
| Date of last smear test: |  |
| What was the result of smear test (if known) | Was this at your GP’s Surgery | Yes | No |

If you do not wish to have a cervical smear test please tick the box. We will make a note of your wishes on your medical records. If you choose not to have a smear test now, it does not mean that you cannot have them again in the future if you change your mind. If you have any queries or anxieties about having a cervical smear, do feel free to discuss these with our Practice Nurses. ❑

I am aware of the benefits of cervical screening but do not wish to have a cervical smear test done at present. I am also aware that I can change my mind about this at any time. ❑

**Signature:**

**Date:**

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| Receptionist to Complete  |
| Checked By: | Date: | Comments: |
| Signature: |  |  |

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| CHILD PATIENT INFORMATION FORM |
| Patient’s last name:First: Middle: | ❑ Miss | ❑ Master |
| Any Delivery Problems? ❑ Yes ❑ No | Birth date: |  | Sex: |
|  / / |  | ❑ M | ❑ F |
| Was your child premature? ❑ Yes ❑ No |
| Has your child had any developmental checks, if so which ones: |
| Has your child had any diseases or operations? ❑ Yes ❑ No  |
| What were these, when did they occur and did they need to be admitted to Hospital ❑ Yes ❑ NoPlease give details:  |
| Any allergies i.e.: Asthma/ Eczema/Other : ❑ Yes ❑ NoPlease give details:  |
| Any allergic/abnormal reactions to medications or vaccinations: ❑ Yes ❑ NoPlease state: |
| Does your child have any medical problems at present: ❑ Yes ❑ NoPlease state: |
| **CHILD PATIENT INFORMATION FORM** |
| Any disabilities or sensory impairment that you would like us to be aware of? ❑ Yes ❑ No |
| Please State: |
| Is your child currently taking prescribed medications? ❑ Yes ❑ No If YES please list below:  |
| Does your child have any significant family history of illness affecting their brothers, sisters, parents or grandparents: ❑ Yes ❑ No

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| --- | --- | --- |
| Diabetes ❑  | Asthma ❑  | COPD ❑ |
| Hypertension ❑  | Heart Disease ❑  | Stroke ❑  |
| Epilepsy ❑ | Thyroid Disease ❑ | Cancer ❑ |
| Depression ❑ | Other Mental Illness ❑ | Other ❑ |

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| Children – 14 – 16 YEARS ONLY  |
| Does your child smoke? | NO | YES (approx. how many per day) Please state: |
| Online Patient Access from 16 Years? |  |  |

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| CHILDREN CONTACT IN CASE OF EMERGENCY |
| Next of Kin:- contact name and details: | Relationship to patient: | Home phone  | Mobile No: |
| Parent  | Guardian | Foster Carer | Other |
| The above information is true and accurate to the best of my knowledge. |
|  |  |  |  |
|  | Patient/Guardian signature |  | Date |

**PLEASE ADD DATES WHEN VACCINATIONS WERE GIVEN:**

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| **CHILD REGISTRATION FORM – PERSONAL IMMUNISATION RECORD** |
| **VACCINATION** | **1st Dose** | **2nd Dose** | **3rd Dose** | **Other** | **Pre-School** | **Booster** | **Given in UK or Elsewhere?****Please state:** |
|  |  |  |  |  |  |  |  |
| **Pertussis** (Whooping Cough)Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Diptheria**Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Tetanus**Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Hib**Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Polio**Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Pneumococcal**Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Men C**Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Hib MenC**Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Rotavirus**Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Influenza**Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Meningitis B**Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **MMR**MeaslesMumps Rubella | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **BCG**Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Hep A**Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Hep B**Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **HPV****Date:** | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |