

# Bute House Surgery

## New Patient Registration Form - Adult



**Today's Date:**

Please complete this confidential questionnaire (one for each adult member of the family to be registered with the Practice).

Please complete in BLOCK CAPITALS and tick the boxes as appropriate.

If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.

Please complete a separate form for each adult family member to be registered.

<b>Full Name:</b>					<b>Telephone Number:</b>	
<b>Mr / Mrs / Miss / Ms / Other.....</b>					<b>Work Number</b>	
<b>Address and Postcode</b>					<b>Mobile Number:</b>	
					<b>E-mail Address:</b>	
					<b>Next of Kin:</b>	
					<b>Next of Kin Contact Number &amp; Relationship to you:</b>	
<b>Date of Birth:</b>		<b>Previous / Mother's surname if different:</b>			<b>Town &amp; Country of Birth</b>	
<b>Marital Status:</b>		<b>Gender:</b>	<b>Male:</b>	<b>Female:</b>	<b>Other residents of your home:</b>	
<b>Occupation:</b>						
<b>Names &amp; Ages of Children</b>						
<b>Housing (Select one)</b>	<b>House</b>	<b>Maisonette</b>	<b>Flat</b>	<b>Mobile Home</b>	<b>NHS Number (if Known)</b>	
					<b>Previous Doctor Telephone No.</b>	
					<b>If applicable, date you first came to live in Britain:</b>	
<b>If returning from Armed Forces:</b>		<b>Your Service or Personnel Number</b>			<b>Your Enlistment Date</b>	
<p><b>Which pharmacy would you like to collect your regular medication from? If you live more than 1 mile from a chemist we can dispense for you at the surgery, otherwise we can send your prescription request to your nominated pharmacy. Rules regarding dispensing eligibility are very strict. If you are eligible to be a dispensing patient but opt to use a pharmacy instead you will NOT be able to change your mind at a later date. Please speak to a member of our dispensary team if you have any queries. Please circle your choice:</b></p>						
Bute House Dispensary (ONLY if you live more than 1 mile from a chemist)	Abbey Pharmacy	Well	Boots Sherborne	Boots Babylon Hill	Boots Yeovil (Middle Street)	Sarah Allard

Would you like access to our online services?( You can order repeat medication and book appointments online 24 hours a day, 7 days a week)				Yes (We will send you your username and password in the post)			
<b>Your height:</b>		Feet / inches	cm	<b>Your weight:</b>	Stones / lbs.	kg	
<b>Your Religion:</b>	C of E	Catholic	Other Christian (state)		Buddhist	Hindu	Muslim
	Sikh	Jewish	Jehovah's Witness		No religion	Other religion (state)	
<b>Your Ethnic Origin: (select one)</b>		White (UK) 9i0		White (Irish) 9i1%		White (Other) 9i2%	
Caribbean 9i3		African 9i4		Asian 9i5		Other Mixed Background 9i6%	
Indian / Brit Indian 9i7		Pakistani / Brit Pakistani 9i8		Bangladeshi / Brit Bangladeshi 9i9		Other Asian Background 9iA%	
Other Black Background		Chinese 9iE		Other 9iF%		Ethnic Category not stated 9iG	
<b>Your main or 1<sup>st</sup> language Spoken / Understood: (select one)</b>		English	Hindi	Gujurati	Urdu	Bengali /Sytheti	Punjabi
Polish	Ukrainian	French	German	Spanish	Other: (Please Specify)		
<b>Smoking, Alcohol Consumption and Exercise:</b>							
<b>Are you currently a smoker?</b>		Yes	No	<b>Have you ever been a smoker?</b>		Yes	No
<b>If so, how many cigarettes / cigars / tobacco do you smoke in a week?</b>			<i>If you are a smoker and want to stop, please ask for information about local smoking cessation services.</i>		<b>How often do you have a drink containing alcohol? (please circle)</b>		Never
							Monthly or less
							2-4 times a month
							2-3 times a week
					<b>How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? (please circle)</b>		4 or more times a week
							Never
							Less than monthly
							Monthly
<b>How much alcohol do you drink on a typical day (Units)? (One unit = 1 small glass of wine, a single measure of spirits, or 1/2 a pint of beer)</b>							Weekly
							Daily or almost daily
<b>How often do you exercise?</b>		<b>No. times per week:</b>		<b>Type(s) of exercise:</b>			
<b>Your Medical Background:</b>							
<b>What illnesses have you had &amp; when?</b>							

<b>What operations have you had and when?</b>		
<b>Do you have any medical problems at present?</b>		
<b>Please list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency) – or attach list from previous GP</b>		
<b>Are you able to administer your own medicines?</b>	Yes	No – please detail specific issues (e.g. swallowing, opening containers)

<b>Are there any serious diseases that affect your Parents, Brothers or Sisters (tick all that apply)</b>	Diabetes	Heart Attack	Heart attack under age of 60	Bowel Cancer	
	Breast Cancer		High Blood Pressure	Asthma	Stroke
	Thyroid Disorder		Any other important Family Illness?		

<b>What immunisations have you had? (please tick all that apply)</b>	Diphtheria	Measles	German Measles	Tetanus	Polio	MMR
	Whooping Cough		Pre-school booster	Triple vaccine (Diphtheria, Tetanus & Pertussis) – 3 doses		

**Specific Needs:**  
Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action. This may include any Sensory Impairment, any physical or mental disabilities, any religious needs or communication difficulties/barriers, phobias or anything else that you feel your new GP should be aware of:

<b>Please state any allergies and sensitivities you have:</b>	
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<p>If you ARE a Carer, please state the name / address / phone number of the person you care for:</p>	<p><u>Person Cared For Contact Details:</u></p>			
<p>If you HAVE a Carer, please state their name / address / phone number and sign here if you wish us to disclose information about your health to your Carer.</p>	<p><u>Carer Contact Details:</u></p>			
	<p><u>Signed:</u></p>		<p><u>Date:</u></p>	
<p>Do you have a "Living Will" (a statement explaining what medical treatment you would not want in the future)?</p>	<p>Yes / No</p>	<p><i>If "Yes", can you please bring a written copy of it for us to scan onto your patient record</i></p>		
<p>Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)?</p>	<p>Yes / No</p>	<p>If "Yes", please state their name / address / phone number/relationship to you:</p> <p>Do they have POA?</p>		
<p><b>Women only:</b></p>				
<p>When was your last smear done?</p>	<p>Date</p>	<p>Was this at your GP's Surgery?</p>	<p>Yes</p>	<p>NO</p>
<p>What was the result of the smear?</p>				
<p>Date of last mammogram (if applicable):</p>	<p>Date</p>	<p>Method of contraception (if used):</p>		
<p>Do you wish to see a doctor in this practice for contraceptive services (including the pill, coil, nexplanon or cap)?</p>			<p>Yes</p>	<p>NO</p>

### Summary Care Records

The NHS Summary Care record is an electronic record of important information about your health. It will be available to health care staff providing your NHS Care. An information pack has been provided.

Are you happy to have a Summary Care Record?	Yes	No	More Time Required to decide:
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### Patient Participation Group

The Practice is committed to improving the services we provide to our patients. To do this, it is vital that we hear from people about their experiences, views, and ideas for making services better. We send information emails regarding the practice such as our quarterly newsletter and also pertinent information about local health services. At times we will also request feedback and a response from patients. You are in no way obliged to respond but it does help us to develop our services for you. We use MailChimp to send non clinical communications to patients. We import your name and email address only into our database we store on their servers. Please tick below to confirm you are happy for us to do this. You can unsubscribe at any time by clicking the link at the bottom of the email you receive.

Yes, I am interested in receiving information from the practice or being part of the Practice Patient Participation Group (Please tick the Box)		I don't have internet access but please could I be sent a paper copy of your newsletter? (Please tick the Box)	
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Patient Signature:		Signature on behalf of Patient:	
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***If you wish to have a 'New Patient Check' please book an appointment at reception. Your new patient check will include having your height, weight and blood pressure taken, and a specimen of urine for testing (it would be helpful if you would bring a specimen with you when coming to the Practice).***

***The Consultation will also establish relevant past medical and family history, including:***

- ***Medical factors - illnesses, immunisations, allergies, hereditary factors, screening tests, current health***
- ***Social factors - employment, housing, family circumstances***
- ***Lifestyle factors - diet and exercise, smoking, alcohol and drug abuse.***

**Thank you for completing this form**

***For more information about the services we offer, please refer to your new patient pack or see our website: [www.butehousesurgery.co.uk](http://www.butehousesurgery.co.uk)***