**A: 40 Colney Hatch Lane, London, N10 1DU**

**T: 020 8883 8214**

**F: 0844 815 1498**

**E:** **Rutlandhouse.surgery@nhs.net**

**Confidential New Patient Registration Questionnaire**

|  |  |
| --- | --- |
| **Surname:** | **First Name(s):** |
| **Date Of Birth:** | **Gender: [ ]** Male **[ ]** Female |
| **Address:**  | **Home Telephone:** |
| **Mobile Telephone:** |
| **Email Address:**  |
| **Consent to SMS: [ ]** Yes **[ ]** No | **Marital Status:**  |
| **Occupation:** | **Place Of Birth:** |
| **Do you have any children? If so, how many:**  | **Previous GP Details (*GP Name, Practice Name & Practice Address*):** **NHS Number:**  |
| **Emergency Contact Name and Number:** |
| **Relationship to Emergency Contact:**  |
| **Are you a Carer?** **[ ]** Yes **[ ]** No**Does someone look after you?** **[ ]** Yes **[ ]** No | **Do you require information about your benefits for Carers? [ ]** Yes **[ ]** No |

**Please indicate your ethnicity**

[ ]  British or mixed British

[ ]  Irish

[ ]  Other White background

[ ]  White & Black African

[ ]  White & Asian

[ ]  Other Mixed background

[ ]  Indian or British Indian

[ ]  Pakistani or British Pakistani

[ ]  Bangladeshi or British Bangladeshi

[ ]  Other Asian background

[ ]  Caribbean

[ ]  African

[ ]  Other Black background

[ ]  Chinese

[ ]  Other

[ ]  Ethnic category not stated

**What is your first language?..............................................................................................................**

**FAMILY HISTORY**

**Please state which member of your family have any of the following conditions i.e. Mother, Father etc.**

|  |  |  |
| --- | --- | --- |
| **Asthma:** | **Stroke/TIA/CVA:** | **Hypertension:** |
| **CHD:** | **Cancer:** | **Diabetes:**  |
| **Epilepsy:** | **Thyroid Disease:**  | **Other:**  |

**LIFESTYLE:**

|  |  |  |
| --- | --- | --- |
| **Height:** | **Weight:** | **BP:** |
| **Diet: [ ]** Balanced **[ ]** Vegetarian **[ ]** Vegan **[ ]** Kosher **[ ]** Halal **[ ]** Low Fat Diet **[ ]** Other |
| **Smoking Status: [ ]**  Current Smoker **[ ]** Ex-Smoker **[ ]** Never Smoked |

**If you are a current or ex-smoker, please indicate how many per day: ………………………………….**

**ALCOHOL** ***Please complete the following Audit C test:***

*Unit definition: 1 Glass of Wine = 1.5 Units 1 Bottle = 10 Unit 1 Pint of Beer = 3 Units 1 Spirit Measure = 1 Unit*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Questions** | **0** | **1** | **2** | **3** | **4** | **Score** |
| How often do you have a drink containing alcohol? | Never | Monthly or less | 2-4 times per month | 2-3 times per week | 4+ times per week |  |
| How many units of alcohol do you drink on a typical day when drinking? | 1-2 | 3-4 | 5-6 | 7-9 | 10+ |  |
| How often have you had 6 or more units if female, or 8 or more if male on a single occasion in last year? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |

**EXERCISE STATUS:** **[ ]** No Exercise **[ ]** Light Exercise **[ ]**  Moderate Exercise **[ ]**  Heavy Exercise

**Sexual Health Lifestyle:** **[ ]** Active **[ ]** Non Active

**Medical History**

|  |  |
| --- | --- |
| **Known Drug Allergies:** |  |
| **Other Allergies:** |  |
| **Serious Illnesses/Operations:** |  |
| **Disabilities:**  |  |
| **Please list Current Medications:** |  |

**FEMALE PATIENTS:**

Are you taking any contraceptive medications?

Please state which one ………………………………………………………………………………………………..