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**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 ………………………………………………………………………………………………..