

The Stansted Surgery

New Patient Registration

Forename(s)..... Surname:.....

Date of Birth:.....

Telephone number – Home..... Mobile.....

Email Address.....

Please indicate if you are happy for us to text remind you of your appointment. Y/N

Please indicate if you are happy for us to email you non clinical issues. Y/N

Please indicate your ethnic origin:

White	British	Irish	Any other white background	
Mixed	White & Black Caribbean	White & Black African	White & Asian	Any other mixed background
Asian or Asian British	Indian	Pakistani	Bangladeshi	Other Asian Background
Black or Black British	Caribbean	African	Any other black background	
Other Ethnic Groups	Chinese	Any other ethnic group		
	I decline to give this information			

Main Spoken Language.....

Is an interpreter needed Y/N?

Occupation.....

Next of Kin.....

Tel Number.....

Relationship.....

Next of Kin Address (If Different).....

.....

Do you have a carer Y/N?

Are you a carer Y/N?

Previous Serious Illness (Include Date Diagnosed).....

.....

Current Serious Illness (Include Date Diagnosed).....

.....

Please list any operations (Include date).....

.....

Please list any allergies.....

Please list any medicines, or other treatments you are currently receiving.....

Have your parents or siblings had:

Relationship:

Heart disease, under the age of 60?

.....

Stroke, under the age of 60?

.....

High Blood Pressure?

.....

Diabetes (insulin or tablets)

.....

Glaucoma

.....

Asthma

.....

Bowel Cancer

.....

Heart Disease (over 60)

.....

Breast cancer

.....

History of cardio-vascular disease:

Have you ever been told by a doctor that you have had a stroke?

Yes/No

Have you ever been told by a doctor that you have had a transient ischaemic attack

Yes/No

Have you ever been told by a doctor that you suffer from angina?

Yes/No

Have you ever been told by a doctor that you have had a heart attack?

Yes/No

Other Diseases:

Do you have a history of Multiple Sclerosis?

Yes/No

Do you have a history of diabetes?

Yes/No

Do you have a history of Epilepsy?

Yes/No

Do you have a history of chronic kidney disease?

Yes/No

Do you have a history of asthma?

Yes/No

Have you had a Tetanus injection within the last 10years?

Yes/No

What is your height

ft

in

or

cm

How much do you weigh?

st

lb

or

kg

Do you smoke: Yes/No

Have you ever smoked: Yes/No

If so, how many per day.....

When did you give up.....

Do you have any food intolerances/dietary problems?

Yes/No

Do you take sufficient exercise?

Yes/No

(Sufficient exercise involves at least three 20minute periods of exercise per week)

Alcohol Use Disorder Identification Test – Consumption (AUDIT-C)

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Pint of Regular Beer/Lager/Cider



Alcopop or Can of Lager



Glass of Wine (175ml)



Single Measure of Spirits



Bottle of Wine

Remember, drinks poured at home are usually bigger

Questions	Scoring system					Your score
	0	1	2	3	4	
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 you are drinking?	1 - 2	3 - 4	5 - 6	7 - 8	10+	
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?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	