NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE

Please complete this questionnaire as fully as possible. The information will help the doctor to make an initial assessment of your health which will help in your future treatment.

GP PRACTICE

Please circle the GP practice you wish to register with:

1. Dr McCandless & Partners   2. Dr McNiff & Partners   3. Dr Ramsey & Partners

PATIENT DETAILS

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

Date of Birth: .... Marital status: ....

Address: ....

.... Postcode: ....

Home tel: .... Mobile: ....

Weight (approx): .... Height: ....

Do you consent to being contacted by text eg appointment reminders, clinic invites:

Yes ☐   No ☐

SMOKING

Please circle the statement that applies to you:

1. I am a smoker
2. I am a non smoker
3. I am an ex smoker

If you are a smoker how many do you smoke?

Cigarettes per day .... Cigars per day .... Ounces of tobacco per day ....

FAMILY HISTORY

Is there any of the following in your family *(father, mother, brother, sister)* before age of 65?

Heart Disease (heart attacks, angina) Yes / No Which family member? ....

Stroke? Yes / No Which family member? ....

Cancer? Yes / No Which family member? ....

Site of cancer? ....

CONTINUED OVERLEAF

MEDICATION

Please give details of any medication which you take (prescribed or otherwise):

Name of drug: .... Name of drug: ....

Dosage: .... Dosage: ....

Name of drug: .... Name of drug: ....

Dosage: .... Dosage: ....

ALLERGIES

Are you allergic to any substances or foods? Yes / No

If yes, please give details:

....

....

PAST MEDICAL HISTORY

Please give details of any hospital treatment as an in-patient:

....

....

Please give details of any chronic medical conditions eg asthma, COPD, diabetes:

....

....

FEMALE PATIENTS

Date of most recent cervical smear: ....

Date of most recent breast screening (if applicable): ....

CARERS

Do you have anyone who looks after you or your daily needs as Carer? Yes / No

Do you care for anyone else? Yes / No

If "Yes", we can pass your details to the local support group; ask at reception for a consent form

Signed .... **Date** ....

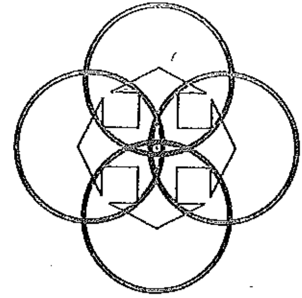
Banbridge Group Surgery

The Department of Health has asked us to record the ethnic origin of all new patients; please tick the description which you feel is most appropriate on the list below.

If you do not wish to provide this information please tick the last option "Information refused".

This information will be added to your medical record.

White British		9S10
Irish Traveller		9I2C
White Irish		9S11
Other White Background		9S12
Mixed White & Black - Carribean		9SB5
Mixed White & Black – African		9SB6
Mixed White & Asian		9SB4
Other Mixed Background		9SB4
Asian or Asian British – Indian		9i7
Asian or Asian British – Pakistani		9i8
Other Asian Background		9iA
Black or Black British – Carribean		9iB
Black or Black British – African		9iC
Other Black Background		9iD
Chinese		9iE
Other Ethnic Background		9iF
Information Refused		9SD



Family Practitioner Services

GMF149 GP LINKS

NHS ORGAN DONATION REGISTRATION (OPTIONAL)

Dear Sir/ Madam,

The statement below can be used to record your wishes on the NHS Organ Donor Register, provided you are over 16 years of age.
By joining the register you are giving your agreement for your organs and tissue to be used for transplantation to save or enhance the lives of others after your death.
For more information, please ask at reception for an information leaflet or visit the website www.uktransplant.org.uk, or call 0845 60 60 400.

Yours faithfully

Renee Greer
for Director of Family Practitioner Services

Surname: ____________________ Forename: ____________________

Date of Birth: __________ Health+ Care Number: ____________________
(on medical card)

Address: ____

Postcode: ____________________ GP Name: ____________________

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. **Please tick the boxes that apply.**

Any of my organs and tissue ☐ or Kidneys ☐ Heart ☐

Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐

Patient's Signature: ____________________ Date: __________