New Patient Registration

Name:	Date of Birth:
Address: Postcode: Telephone: Home – Work – Mobile – Male/Female:	Ethnicity (see attached sheet for info): Do you require an interpreter, if YES in which language? Occupation: Height: Weight:
Last Doctors Name: Surgery: Address:	Next of Kin: Address: Telephone:

Have you been registered with this surgery previously Yes/No

Medical problems -Please list any medical problems that you have had or operations

Date	Medical problem/Operation

Are you taking any medication? If yes please list below – If you have a repeat prescription slip from your previous medical practice please attach it to this form

Name of drug	How many times each day is the drug taken?	Dose of drug

ALLERGIES

Do you have any allergies?	
If YES please list	

SMOKING

Do you smoke?	
IF NO have you ever smoked?	

Carers – The practice recognises that carers need specific support and would therefore like to know if you care for a family member or friend. **Please complete the attached "Are you a Carer? Do you have a Carer?" form.**

Family history - Have any of your family i.e. Father, Mother, Brothers or Sisters suffered from **diabetes** or **heart disease**? If yes please fill in the box below.

	Who was affected and what were their ages when FIRST affected
Diabetes	
Heart disease	

Does any other illness run in your family e.g. **high blood pressure**, **high cholesterol**, **cancer**, **glaucoma**? Please list below in the box.

Illness	**Who was affected and what were their ages when first affected?**

Alcohol - Please tick the statement which most closely describes your usual average alcohol intake (1 Unit = 1 glass wine, ½ pint of beer or a single measure of spirit). *It is advised that women drink no more than 14 units per weeks and that men drink no more that 21 units per week*

I never drink alcohol		**I drink within the recommended limits**		**I drink more than the recommended limits**	

Exercise - Healthy exercise usually involves activity that usually lasts for at least 20 minutes, raises the pulse and produces hard breathing. In younger people this might be running, cycling, aerobics or swimming or for older people this may be a brisk walk. How often do you take this type of exercise? Please tick the box which applies to you.

Daily		**4 times weekly**		**Once weekly**		**Seldom**	

I cannot take exercise because of disability	

Female patient's only - Cervical smears - The practice advises Cervical Smears for the 20-60 age groups every 3 years.

Are you up to date with your smears? YES / NO / Not Applicable		**Please tick if you have never had a smear**	

Household Composition: Does anyone else live with you?

Name	Relationship to you

Housing: What best describes your current housing? [please tick] most appropriate description]

Owner occupier	
Rented -Housing association or Council	
Rented-Private landlord	

Homeless or Temporary Accommodation	
Other	

Communication Difficulties; Do you have any trouble, eg speaking/ hearing/ seeing/ reading or writing? Please tick any that apply to you

Poor hearing/ Deafness	
Speech difficulties	
Poor vision/ blindness	
Difficulty on the telephone	
Difficulty reading and/or writing	

Signature of patient	**Date**

Thank you for completing this form. Please hand back to the reception desk

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Administration section only: 1) *Receptionist to tick here* if telephone consultation (TC) made for rpt prescriptions or face to face consultation (F/F) made - _____ (T/C) _____ (F/F)
2) *Data processor to tick and sign the form and date here* - _____ (SPICE) _____ (ETHNICITY) _____ (CARER) _____ (Signature) _____ (date)

ETHNICITY FORM – READ Coding template

If you have already completed this form, please **do not** complete it again.

NAME: _____

DATE OF BIRTH: _____

What is your **ethnic group**? (Choose **ONE** section from A to F then tick **ONE** box which best describes your ethnic group)

READ codes

A. WHITE

- ❑ Scottish **9S13**
- ❑ Other British **9S10**
- ❑ Irish **9S11**
- ❑ Gypsy / Traveller **9T2**
- ❑ Polish **9i2F**
- ❑ Other white ethnic group **9S12**

B. MIXED OR MULTIPLE ETHNIC GROUPS

- ❑ Any mixed or multiple ethnic groups **9SB**

C. ASIAN, ASIAN SCOTTISH OR ASIAN BRITISH

- ❑ Pakistani, Pakistani Scottish or Pakistani British **9S7**
- ❑ Indian, Indian Scottish or Indian British **9S6**
- ❑ Bangladeshi, Bangladeshi Scottish or Bangladeshi British **9S8**
- ❑ Chinese, Chinese Scottish or Chinese British **9S9**
- ❑ Other Asian, Asian Scottish or Asian British **9SH**

D. AFRICAN

- ❑ African, African Scottish or African British **9S3**
- ❑ Other African **9SA5**

E. CARIBBEAN OR BLACK

- ❑ Caribbean, Caribbean Scottish or Caribbean British **9S2**
- ❑ Black, Black Scottish or Black British **9S41**
- ❑ Other Caribbean or Black **9SG**

F. OTHER ETHNIC GROUP

- ❑ Arab, Arab Scottish or Arab British **9iF9**
- ❑ Other ethnic group **9SJ**

❑ IF YOU WOULD PREFER NOT TO ANSWER PLEASE TICK HERE **9SD**

❑ IF YOU DO NOT KNOW YOUR ETHNICITY PLEASE TICK HERE **9SE**

Are you a carer? Do you have a carer?

DURHAM ROAD MEDICAL GROUP and **VOCAL Carers Centre** are working in partnership to identify and support carers.

What is a carer?

Carers are family members or friends who are looking after or supporting someone who is frail, ill or disabled. Caring roles vary from situation to situation. Carers can be involved in a large number of tasks including assisting with bathing, dressing, giving medication, helping with paying bills and organizing the house among many others.

How can VOCAL help?

Caring can present many challenges and VOCAL offers free services to support carers when dealing with them. The team at VOCAL can answer your questions, provide practical support to help you access services like respite and home help as well as financial entitlements, provide training and information, a listening ear or counselling.

What happens next?

If you are a carer fill in the form below or if you have a carer pass this form to them. On completion please hand in to reception.

When VOCAL receives a completed form we will send you an information pack, which includes information about carer's rights and services to support carers and people with disabilities or in poor health. We will also add you to our mailing list and send you a newsletter three times a year.

Durham Road Medical Group will indicate on your records that you have a caring role enabling them to provide you with appropriate health care.

Your name: _____

Address: _____

Postcode: _____

Telephone/mobile: _____

Email address: _____

We will use this information to send useful carer news and info

Date of birth: _____

Number of years caring: _____ Number of hours caring per week: _____

How would you describe your ethnicity: _____

Information about the person you care for:

Relationship you: _____ Illness/condition: _____ Age: _____

Do you care for more than one person? Yes ☐ No ☐

(If yes, please use the space on the back of this form to list age and condition of other people that you support

I would like **DURHAM ROAD MEDICAL GROUP** to record that I am caring on my records **YES/NO**

I would like VOCAL to send me an information pack and add me to their mailing list **Yes/NO**

I would like VOCAL to call me at home to discuss my situation **YES/NO**

Return freepost to VOCAL, Freepost 3172, Edinburgh, EH1 0XG

TEXT MESSAGING AT DURHAM ROAD MEDICAL GROUP

Here at Durham Road Medical Group we are introducing a new text messaging system. This is where you can receive a text message reminding you of upcoming appointments, inviting you in for healthcare reviews (COPD, asthma, diabetes etc.) It can also let you cancel appointments or accept these invitations without having to come in or contact us.

If you are happy and would like to receive text messages from Durham Road then please tick the **'ACCEPT'** box, fill out your personal details and sign at the bottom of the page.

If you would not like to receive text messages from Durham Road then please tick the **'DECLINE'** box, fill out your personal details and sign at the bottom of the page.

Please note; we will only send information that is relevant to the individual and will not send spam. We will also not send any sensitive information such as test results via text message.

I have read and understood how my data will be used by Durham Road Medical Group and **ACCEPT AND CONSENT** to receiving text messages from the practice. ☐

I have read and understood how my data will be used by Durham Road Medical Group and **DECLINE AND DO NOT CONSENT** to receiving text messages from the practice. ☐

Name _____

Date of Birth_____

Mobile Number_____

Signature_____ Date_____