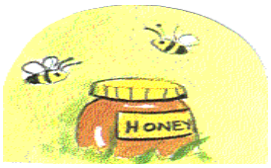

Honeypot Medical Centre

Patient Registration Form

Dear Patient

As a patient of Honeypot Medical Centre we need to be sure that we have all of your details on our system and that they are correct and up to date.

To enable us to check our records we would be most grateful if you would kindly take a few minutes to complete this questionnaire.

If there is anything you cannot answer or are not sure about please contact a member of staff who may be able to assist you.

It is important that you complete **this form fully**, with particular emphasis on your telephone number where you may be contacted during daytime hours.

Thank you for your co-operation

EMIS NO:

STAFF SIGN OFF

Registration Details Checked by		***Date:***	
Computer Input By		***Date:***	

PERSONAL DETAILS	
Title (Mr/Mrs/Ms/Miss/Other	***Date of Birth***
Surname	***First names***
Address ***Postcode***	

TELEPHONE NUMBERS & MISC.INFORMATION		
Home	***Work***	***Mobile***
Marital Status		
Occupation		
Next of Kin	***Tel No.***	
Previous Doctors Name & Address		
Are you a Carer? **YES** **or** **NO** (delete as applicable)		

LIFESTYLE	
Do you Smoke?	***Non-Smoker:***

Current Smoker – *How many per day?* _____ *Trying to Stop?* **YES or NO**

Ex-Smoker – *Please state year you stopped smoking:*

For Patients who smoke hand out the Advice Details and update template

Do you Drink Alcohol?

Please circle your answer for each question and your score at the end

	Questions	Scoring System 0	1	2	3	4	Your Score
Q1	How often do you have a drink that contains alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
Q2	How many standard alcoholic drinks do you have on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 8	10+	
Q3	How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Score Total =

LIFESTYLE	
Weight:	***Height:***
Do you Exercise? **YES or NO** ***What Type:*** ***How Often:***	
Are you on a Special Diet? (eg vegetarian, low fat, vegan, diabetic)	

COMMUNICATION

1a 1st Language Spoken

Please **tick one** of the following options as your 1st language

CODE	LANGUAGE	TICK ONLY ONE OPTION	CODE	LANGUAGE	TICK ONLY ONE OPTION
1	Akan (Ashanti)		31	Kurdish	
2	Albanian		32	Lingala	
3	Amharic		33	Luganda	
4	Arabic		34	Makaton (sign language)	
5	Bengali & Sylheti		35	Malayalam	
6	Brawa & Somali		36	Mandarin	
7	British Signing Language		37	Norwegian	
8	Cantonese		38	Pashto (Pushtoo)	
9	Cantonese and Vietnamese		39	Patois	
10	Creole		40	Polish	
11	Dutch		41	Portuguese	
12	English		42	Punjabi	
13	Ethiopian		43	Russian	
14	Farsi (Persian)		44	Serbian/Croatian	
15	Finnish		45	Sinhala	
16	Flemish		46	Somali	
17	French		48	Spanish	
18	French creole		49	Swahili	
19	Gaelic		50	Swedish	
20	German		51	Sylheti	
21	Greek		52	Tagalog (Filipino)	
22	Gujarati		53	Tamil	
23	Hakka		54	Thai	
24	Hausa		55	Tigrinya	
25	Hebrew		56	Turkish	
26	Hindi		57	Urdu	
27	Igbo (Ibo)		58	Vietnamese	
28	Italian		59	Welsh	
29	Japanese		60	Yoruba	
30	Korean		200	Other	

1b Other Spoken Languages ……

1c Do you need support with spoken English? or support with written English?

☐ Yes ☐ No ☐ Yes ☐ No

1d 9NU0 Is an Interpreter needed (including BSL)

☐ Yes ☐ No

Please state which language ……

1e 668B Do you require Large print

Yes **No**

Translated materials please state which language ……

2. Do you use Hearing Aid or require Hearing Loop?

☐ Yes ☐ No ☐ Hearing Loop

CULTURAL/RELIGIOUS STATUS

☐ 135S Buddhism/Buddhist ☐ 135A Christianity (Including Church of England, Catholic Protestant, Methodist, Baptist) ☐ 1359 Islam/Muslim

☐ 1358 Hinduism/Hindu ☐ 1357 Jehovah's Witness ☐ 1355 Judaism/Jewish

☐ 135Q I do not wish to answer ☐ 135D None ☐ 135B Sikhism/Sikh

☐ Any other religion, (please state)……

ETHNICITY

To Which of These Ethnic Groups Do You Feel You Belong?
Please tick one box

White			**Black or Black British**		
A	British		M	Caribbean	
B	Irish		N	African	
C	Any other White background		P	Any other Black background	
Mixed			**Other Ethnic Groups**		
D	White and Black Caribbean		R	Chinese	
E	White and Black African		S	Any other ethnic group	
F	White and Asian				
G	Any other mixed background		Z	Not stated	
Asian or Asian British					
H	Indian				
J	Pakistani				
K	Bangladeshi				
L	Any other Asian background				

MEDICAL HISTORY			
Describe your Current Health by ticking one of the following boxes			
Excellent	**Good**	**Fair**	**Poor**
Do you suffer from any Major illness? **(Give Details)**			
Do you suffer from any Allergies? **(Please List)**			
Have you had any operations or major illness?			
Are you on medication? **(Please List)**			
When did you last have a Tetanus Injection?			

FAMILY HISTORY *(Tick if Parents or Siblings have had any of the following & state age when illness started)*			
	Tick	**FAMILY MEMBER**	**AGE ILLNESS BEGAN**
High Blood Pressure			
Stroke			
Heart Attack/Angina			
Diabetes			
Glaucoma			
Asthma			
Cancer (State Where)			
Osteoporosis			

for Women Only
What is your method of Contraception?
When did you last have a Cervical Smear? ***Month & Year*** _____ ***Where was it Done?*** _____***Was it Normal?*** **YES or NO**
Have you had a Mammogram? **YES or NO If YES state** ***Month & Year*** _____ ***Where was it Done?*** _____***Was it Normal?*** **YES or NO**
Have you been Immunised against Rubella? **YES or NO** ***Year*** _____ ***Where?*** _____

for Children Under 5 Years ONLY					
Has your child received the following vaccinations? **(State if the FULL course was not received)**					
	YES	**NO**	**Don't know**	**Date of last vaccine**	**Where was it given**
DTP (Triple Vaccine) *					
HiB (Haemophilus) *					
Polio *					
Meningitis C *					
MMR 1 **					
Pre-School Boosters					
MMR 2 ***					
DtaP ***					
Polio ***					
*** Usually at 2, 3, 4 months**		**** Usually between 12-18 months**		***** Usually between 4-5 Years**	

SELF COMPLETED	
SENT THROUGH POST	
THROUGH INTERPRETER	
DATE COMPLETED:	

I UNDERSTAND THAT THIS INFORMATION WILL BE USED EXCLUSIVELY IN RELATION TO MY HEALTHCARE

Signed …… Date……

Thank you for your time