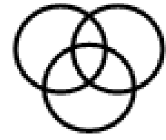
For staff use only:					
HCA		***Time***		***Date***	
ID Seen by:				***Date***	

Three Villages Medical Practice



New Patient Registration Pack

Welcome to
Three Villages Medical Practice

Please complete in BLOCK capitals
Please ask a member of staff if you have any questions

NEW PATIENT REGISTRATION CHECKLIST

TWO forms of the following ID ***one must show your home address (to check you are within the practice catchment area):***	√	**N/A**
Passport		
Driving Licence		
Utility Bill		
Children under 16:		
Birth certificate		
Adult with parental responsibility registered with us		
Repeat Medications:		
If you are taking repeat medications please bring a copy of your current prescription		
New patient appointment		
As a new patient at Three Villages Medical Practice you are invited to attend an optional new patient health check		

Delete as appropriate: I DO / DO NOT wish to book a new patient appointment	**Signed:**	**Dated:**

****Please note the registration process can take up to 3 working days to be processed****

PERSONAL DETAILS						
Surname:		**Previous surname(s):**				
Forename(s):		**Title:**				
Date of Birth:		**Gender:**	**M**		**F**	
ADDRESS						
House Name/ Number:		**Street Name:**				
Town:		**Postcode:**				
CONTACT DETAILS						
Home		**Mobile**				
Work		**E-mail**				

NEXT OF KIN DETAILS									
Surname					**Forename(s)**				
House name/ Number:					**Street Name:**				
Town:					**Postcode:**				
Home Tel:					**Mobile:**				
Relationship to patient:									
Emergency Contact?	**Y**		**N**		**Can Discuss Records?**	**Y**		**N**	

CARERS INFORMATION									
Are you a carer?	**Y**		**N**		**Do you have a carer?**	**Y**		**N**	
If you have answered yes to either of the above questions please ask at reception for further carers information									
INFORMATION OR COMMUNICATION NEEDS									
Do you have any information or communication needs?						**Y**		**N**	
If yes, please specify what they are, e.g. large print or easy to read info or if you need help communicating with us such as: British Sign Language									
If you do not wish to be contacted via any of the above methods of contact please state which method here:									

EMPLOYMENT/EDUCATION	
Occupation(s):	
School attended (if of school age):	

PATIENT ETHNIC ORIGIN QUESTIONNAIRE

This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act.

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

Choose ONE section from A to F, and then tick ONE box to indicate your background.

A White

	British
	Irish
	Any other white background please write below

B Mixed

	White and Black Caribbean
	White and Black African
	White and Asian
	Any other mixed background please write below

C Asian or Asian British

	Indian
	Pakistani
	Bangladeshi
	Any other Asian background please write below

D Black or Black British

	Caribbean
	African
	Any other black background please write below

E Chinese or other ethnic group

	Chinese
	Any other please write below

F Declined

	I do not wish to state

Which religion do you practice?		Do not wish to state	
Which WRITTEN language Do you read?		Do not wish to state	
Which SPOKEN language Do you understand most?		Do not wish to state	

PAST MEDICAL HISTORY		
	Please tick as appropriate	Diagnosis date
High blood pressure		
Cholesterol problems		
Heart disease / attack / angina		
Asthma		
COPD		
Diabetes		
Cancer Where?		
Arthritis		
Other:		

VACCINATIONS			
	Date given		**Date Given**
Diptheria		Polio	
German Measles		Tetanus	
Cholera		Measles	
Yellow Fever		MMR	
Whooping Cough		Other	

SMOKING STATUS								
Current Smoker:	Y		N		Never smoked:	Y	N	
What do you smoke:	Cigarettes		Cigars		Roll ups		Other	
How many do you smoke per day?								
Ex smoker	Y		N		When did you stop smoking?			
How many did you smoke per day?					How many years did you smoke for?			
Are you interested in giving up smoking? Yes / No If you have answered yes, please enquire at your new patient appointment or ask at reception for more information.								

DIET					
Weight Reducing		Average		Vegan	
Healthy Diet		Poor Diet		Vegetarian Diet	

HEIGHT/WEIGHT		
Height:		CM / FOOT
Weight:		KG / STONE

ALLCOHOL CONSUMPTION

UNITS:

1 pint regular beer/lager/cider = 2 units
1 glass of wine (175ml) = 2 units
Bottle of wine = 9 units
Alcopop or can of lager = 1.5 units
1 spirit measure = 1 unit

Questions	Scoring System					Your score
	0	1	2	3	4	
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	
How many standard alcoholic drinks do you have on a typical day when drinking?	1-2	3-4	5-6	7-9	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less Than monthly	Monthly	Weekly	Daily or Almost daily	

FAMILY HISTORY

Is there any family history of the following? *(Please tick those that apply and state which relative)*

		Relative(s)			Relative(s)
Heart Disease/ Attacks / Angina			Breast cancer		
High Blood Pressure			Ovarian cancer		
High Cholesterol			Lung cancer		
Asthma			Bowel cancer		
Diabetes			Stomach cancer		
COPD			Skin cancer		
Stroke			Prostate cancer		
Rheumatoid Arthritis			Other cancer:		
Tuberculosis			Other condition:		

CURRENT MEDICATIONS

- Please list the name, dose and how often you are taking the medication.
- Please bring the counterfoil / right hand side of your prescription medications from your previous doctor with you.
- Please bring your current medication with you to the surgery.

Name	Dose	How many times during the day do you take it?

ALLERGIES

Please list any drug and food allergies you have:

General Practice Physical Activity Questionnaire

Please tell us the type and amount of physical activity involved in your work.

		Please mark one box only
a	I am not in employment (e.g. retired, retired for health reasons, unemployed, full-time carer etc.)	
b	I spend most of my time at work sitting (such as in an office)	
c	I spend most of my time at work standing or walking. However my work does not require much intense physical effort (e.g. shop assistant, hairdresser, security guard, child-minder etc.)	
d	My work involves definite physical effort including handling of heavy objects and use of tools (e.g. plumber, electrician, carpenter, cleaner, hospital nurse, gardener, postal delivery workers etc.)	
e	My work involves vigorous physical activity including handling of very heavy objects (e.g. scaffolder, construction worker, refuse collector, etc.)	

During the *last week,* how many hours did you spend on each of the following activities?

Please answer whether you are in employment or not

		None	Some but less than 1 hour	hour but less than 3 hours	hours or ore
a	Physical exercise such as swimming, jogging, aerobics, football, tennis, gym workout etc.				
b	ycling, including cycling to work and during leisure time.				
c	Walking, including walking to work, shopping, for pleasure etc.				
d	Housework / Childcare				
e	Gardening / DIY				

How would you describe your usual walking pace? Please mark one box only.

Slow pace (i.e. less than 3 mph)	☐	Steady average pace	☐
Brisk pace	☐	Fast pace (i.e. over 4mph	☐

Three Villages Patient Participation Group

What is a Patient Participation Group [PPG]?

Our Patient Participation Group brings together patient volunteers, GPs and practice staff. They meet regularly with the Practice manager, GPs and staff to discuss the services provided, improvements, accessibility and patient experiences.

What does the PPG do?

- Contributes to the continuous improvement of services, ensuring practice is more responsive to the needs and wishes of patients.
- Fosters improved communication between the practice and its patients.
- Helps patients to take more responsibility for their health.
- Provides practical support and help to implement change.
- We suit local needs and determining of own activities according to the needs of the community and the practice.
- We build a relationship between the practice and its patients that breaks down the barriers and shares information.

If you would like more information about the PPG please ask at reception.

Please only complete this section if you wish to join the PPG

Mr / Mrs / Miss ………………………………………………………… Age ……….

Address: ……………………………………………………………………………….

……………………………………………………………………………………….

Postcode……………………………………………………………………………….

Daytime contact number: ………………………………………………………………

Email Address: [Please print]…………………………………………………………...

I would like to join the Three Villages Medical Practice Patient Participation Group

- ☐ Please add me to the mailing list for the future meetings
- ☐ Please add me to the list of email / website participation
- ☐ Please contact me to discuss this further

Please tick as appropriate

Signed: ________________________ Date: _________________

Patient Online Access Registration Form

By signing up to online services you will be able to use a website or app to: book or cancel appointments online with a GP, order repeat prescriptions online and view parts of your GP record, including information about medication, allergies, vaccinations, previous illness and test results.

Full Name:		DOB:	
Address:			
Tel No(s):			
E-mail Address:			

I wish to have access to the following online services (tick all that apply):

Booking appointments	
Requesting repeat prescriptions	
Access to my core summary record (medication and allergies)	
Please ask for a further application form if you wish to access your detailed record	

I will be responsible for the security of information that I see or download	
If I choose to share my information with anyone else, this is at my own risk	
I will contact the practice as soon as possible if I suspect my account has been accessed by someone without my consent	
If I see information in my record that is not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible	

Patient's signature:	
Date:	