Capelfield Surgery Registration Form

SECTION A: TO BE COMPLETED BY ALL

Title:	**Surname*:**	**First Name(s)*:**
Marital Status: Married / Single / Other (Delete where nec-	☐ **Male:** ☐ **Female:** (Please tick)	
Address:	**Postcode:**	
Date of Birth*:	**Nationality*:**	
Mobile Number*: 07	**Home Tel*:**	
Email:	**Are you a carer? Yes / No**	

Main Spoken Language*: **Do you need an interpreter? Yes / No**	**BP reading:** ***Use machine in waiting room***	**Height*:**	**Weight*:**

Ethnicity*:

White -	British	☐	
	Irish	☐	
	Other…… (please state)	☐	
Mixed -	White/Black Caribbean	☐	
	White/Black African	☐	
	White/Asian	☐	
	Other Mixed …… (please state)	☐	
Asian or Asian British -	Indian	☐	
	Pakistani	☐	
	Bangladeshi	☐	
Black or Black British-	Caribbean	☐	
	African	☐	
Other Ethnic Group -	Chinese	☐	
Other ……(please state)		☐	

Family History*: (Please tick if you have a family history of any of the following conditions)

CVA/Stroke		**Family member:**	**Glaucoma**		**Family member:**
Diabetes		**Family member:**	**High Blood Pressure**		**Family member:**
Asthma		**Family member:**			
Breast Cancer		**Family member:**	**Heart Disorders**		**Family member:**
Cholesterol		**Family member:**			

Do you have any health problems/ disabilities? ***If so, please state.***	**Please list the names of any medication that you are currently taking***
Are you receiving hospital treatment*? Please give brief details	

SECTION B: TO BE COMPLETED BY ADULTS AND CHILDREN ABOVE 14 ONLY

Do You Smoke*? (Please tick) **Yes** ☐ **ex-smoker** ☐ **Never Smoked** ☐

If yes, how many cigarettes* do you smoke per day? 1-9 ☐ 10-19 ☐ 20-39 ☐ 40+ ☐

Total time smoked in (years) ☐ Would you like help to give up smoking? Yes ☐ No ☐

If you are an ex-smoker, please state the approximate date when you gave up ☐ / /

How many cigarettes did you smoke per day? ☐ *Cigarettes = any tobacco product (pipes etc)

Do you use electronic cigarettes? ☐

Do You Drink Alcohol*? Yes ☐ **No** ☐

If YES, average units per week (1 unit = 1 glass of wine/1measure of spirits/half a pint of beer) ☐

PLEASE COMPLETE THE ALCOHOL QUESTIONNAIRE

FOR WOMEN ONLY: If you are unsure of these dates, please leave blank.

When was your last cervical smear? ☐

Have you had a hysterectomy*? Yes ☐ No ☐

Have you had a mammogram? Yes ☐ No ☐ If yes, please give the date: ☐

SECTION C: FOR CHILDREN (aged 16 or under) ONLY*

VACCINATIONS: Please bring your child's **RED BOOK**.
If you have lost your red book, please contact your previous GP surgery for a print out of your child's vaccination record (This is usually provided for free)

Any other information that you feel relevant concerning your child:

Tick if you would like your clinical data to be withheld from the Summary Care Record ☐

SECTION D: DECLARATION to be signed by all patients/guardians

I declare to the best of my knowledge that the information provided is correct.

SIGNED: …….. DATE:

PATIENT / PARENT / GUARDIAN (delete where appropriate)

For Office Use Only:
Reception checklist-
Section A & B Completed? Yes / No
Child's Red Book Photocopied? Yes / No / Enclosed
Proof of ID enclosed? Yes / No
Proof of address enclosed? Yes / No

DATE RECEIVED …….. INITIAL HERE……..