Capelfield Surgery Registration Form 2018
(complete both sides)

PLEASE PROVIDE X2 PROOF OF ADDRESS AND X1 PROOF OF ID

Section A (complete all parts)

Title:	Surname:	First Names:	
Marital Status:		Male □ Female □	Date of Birth:
Address:			
Postcode:		Email:	
Home Telephone:		Mobile Telephone:	
What is your Ethnicity? White British White other ……..(specify)	Mixed ……(specify) Asian British Asian other …… (specify)	Black British Black other……(specify) Other ……(specify)	
Main Spoken Language:		Interpreter needed? Yes□ No □	
Using the machine in the waiting room please answer the following:			
Height:	Weight:	BP:	Pulse:
Do you have any health problems? If so, please list :			
1.	2.	3.	
4.	5.	6.	

Section B (over the age of 14 only)

Do you smoke? Yes □ No □	Cigarettes □ Cigars □	
If you are an ex-smoker, what date did you give up smoking?	How many did you smoke per day?	If you are a smoker, how many do you smoke per day on average?
Would you like help to stop smoking? Yes □ No □	How many years have you smoked for?	Do you use electronic cigarettes? Yes □ No □
Do you drink alcohol? Yes □ No □ (if yes, please complete the questions below and overleaf)		
How Many Units of Alcohol do you drink in a week? ……units (use key)	**KEY:** **1 unit:** Single measure of spirits **1.5 units:** Can of lager/Alcopop **2 units:** Pint of regular beer /lager/cider/ glass of wine	

	ALCOHOL Questions	**Scoring system**					**Your score**
		0	**1**	**2**	**3**	**4**	
FAST Questions 1-4	1. How often do you have 8 (men) / 6 (women) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
	2. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
	3. How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Capelfield Surgery Registration Form 2018
(complete both sides)

PLEASE PROVIDE X2 PROOF OF ADDRESS AND X1 PROOF OF ID

	4. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
						FAST SCORE If score is 3 or more continue with Questions 5-15	
AUDIT TEST Questions 5-15	5. 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	
	6. How many standard alcoholic drinks do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	
	7. How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
	8. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
	9. How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
	10. How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
	11. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
	12. How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
	13. How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
	14. Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes during the last year	
	15. Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	
						AUDIT SCORE	

Next of Kin Name:	Next of Kin Relationship:
Next of Kin Telephone:	Next of Kin Address:
Tick here if you would like your clinical data to be withheld from the Summary Care Record □	Would you like to be registered for online patient access to your medical records? Yes □ No □
Signed Patient/Guardian/Parent:	Date:

Reception use only:

Section A&B completed? YES/NO
Child Red Book photocopied? YES/NO/OTHER:
Proof ID: Yes/No
Proof of address: Yes/No
Date received:
Initial here: