REGISTRATION FORM – ADULTS (16 YEARS +)

Please remember to let us know if your details change

Patient details (please write in CAPITAL LETTERS)			
Title:		**Forenames**:	
Male / Female		**Surname/Family name:**	
Address:			
Any special access instructions?	Key safe code:		
Phone number(s):	Home: Work: Mobile:		
Email address:			
Date of birth:		**NHS number:**	

Ethnic origin: (please tick as appropriate)						
White	White British			**Asian / Asian British**	Bangladeshi	
	White Irish				Other Asian background	
	Other white background			**Black / Black British**	Carribean	
Mixed	White and Black Carribean				African	
	White and Black African				Other black background	
	Other mixed background			**Other ethnic groups**	Chinese	
Asian / Asian British	Indian				Any other ethnic group	
	Pakistani			**Not stated**		

What is your main spoken language?		Do you need an interpreter?	Yes / No

Next of kin details: (optional)			
Name:		Relationship:	
Phone number(s):			
Can we contact them in an emergency?		Yes / No	
Can we tell them medical information about you?		Yes / No	

Are you a carer	Yes / No	Who for?	
Do you have a carer?	Yes / No	Who is your carer?	
Are you a military veteran?	Yes / No		

Communications from the practice	
Can we send you information to the email address above?	Yes / No
Can we send you text message reminders / information?	Yes / No
Can the Patient Group enrol you as a member and email information to you?	Yes / No

Please sign below, and then turn over to complete some additional information.
Signature: Date:

BACKGROUND HEALTH INFORMATION

Smoking (please tick as appropriate)			
Are you a	Current smoker?		How much of what?
	Ex-smoker?		When did you stop?
	Never smoked?		
Smoking cessation advice is available from our nurses. Please ask at reception to book an appointment.			

Alcohol	
Do you drink alcohol? Yes / No	Average units per week:
(1 unit = 1 small glass of wine / measure of spirit / half a pint of beer)	
If you drink alcohol, please complete the questionnaire below:	

AUDIT C questionnaire	**Scoring system**					**Your score**
	0	**1**	**2**	**3**	**4**	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4+ times a week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					Total:	
If you score 5 points or more, you may be drinking more than is healthy for you. Our nurses would be happy to discuss this with you.						

Do you have any allergies?	Yes / No	Details:
What is your height?		
What is your current weight?		