Leagrave Surgery

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Luton LU4 9QZ

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New Patient Registration Form

Forename	*Surname*	
NHS Number	*Previous Surname (if applicable)*	
Present Address (including post code)		
Home Telephone	*Work Telephone*	*Mobile Telephone*
Date of Birth	*Sex*	*Marital Status*
Country of Birth	*First Language*	*Second Language*
Are you a Carer?	*If you are a Carer, who do you care for, and what is your relationship?*	

Ethnic Origin (please tick)

- ☐ *British*
- ☐ *Irish*
- ☐ *Other White*
- ☐ *White & Black Caribbean*
- ☐ *White & Black African*
- ☐ *White & Asian*
- ☐ *Other mixed*
- ☐ *Indian*
- ☐ *Pakistani*
- ☐ *Bangladeshi*
- ☐ *Other Asian*
- ☐ *Caribbean*
- ☐ *African*
- ☐ *Other Black*
- ☐ *Chinese*
- ☐ *Other group (please state)*

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Previous GP

Doctor's Name	*Telephone Number*
Surgery Address (including post code)	

Medical History

Please provide information regarding your general health

What is your height?	*What is your weight?*
How much do you smoke? (per day)	*How much do you drink? (per week)*
When did you stop smoking? (if applicable)	*How much did you used to smoke? (if applicable)*
What is your occupation?	
How much exercise do you take?	
Do you suffer from any allergies or intolerances? (please give details)	
Is there any family history of heart disease, cancer or other conditions? (please give details including age and relationship)	

Please provide details of any regular medication being taken (including the contraceptive pill)

Name	*Dosage*	*Frequency*
Name	*Dosage*	*Frequency*
Name	*Dosage*	*Frequency*

Please provide details of any serious illnesses, operations, X-Rays or other tests. (Please list the most recent first, using a separate sheet if necessary)

Date	*Details*
Date	*Details*
Date	*Details*
Date	*Details*

What vaccinations have you received? (Please provide the date for each of the following, if applicable)

Diphtheria	*Tetanus*	*Typhoid*
Cholera	*Whooping Cough*	*Polio*
Measles	*Mumps*	*Rubella*
MMR	*Other (please give details)*	
DTP		

Additional details for Female Patients only

Have you ever had a miscarriage? *If so please provide the date(s)*		
Have you ever had a termination? *If so please provide the date(s)*		
Have you ever had a hysterectomy? *If so please provide the date*		
What method of contraception are you using? *(please state "none" if appropriate)*		
Date of last smear test, and result		
Please provide the date(s) of birth and sex of any children. *(Please use a separate sheet if necessary)*		

Summary Care Record:

The summary care record will contain your allergies, adverse reactions and current medication. This can be shared nationally with those medical staff who have a legitimate reason to look at your record with your permission. If you wish to have a summary care record you do not need to do anything as this will happen automatically and be created from your GP record. If you do not wish to have a summary care record then please ask for an opt-out form at reception. This can be done at any time. If you would like further information on the summary care record please ask at reception or visit www.nhscarerecords.nhs.uk.

Signed …….. Date ……

This form should be completed and handed to reception when registering at the practice. You should also bring with you two forms of identification; one should contain a photograph (such as a passport or photo driving licence) and the other should provide address confirmation (such as a recent utility bill or a bank statement).