Kingsthorpe Medical Centre

New Patient Registration Form

Please complete in **BLOCK CAPITALS** and tick the boxes as appropriate Please complete a separate form for each family member to be registered

Mr/Mrs/Miss/Ms/Other		Full name
Home phone number	Work phone number	Mobile number
Address and post code Email address		Next of kin – name Relationship to you Address Post code Telephone number

Please list below any medical conditions you may have, e.g. diabetes	
Name of condition	*Date or year of diagnosis*

Please list below any surgeries you may have had, e.g. appendectomy	
Type of surgery	*Date or year of surgery*

Please list below any medication prescribed by a GP that you take on a regular basis or provide us with a repeat medication request form		
Name of Medication	*Dose*	*Frequency*

Created: November 2020

Please list below any serious diseases that affect any member of your immediate family (grandparents, parents, siblings), e.g. diabetes, breast or bowel cancer, or heart attacks		
Condition	*Family member*	*How old were they?*

Do you wish to give someone permission to speak on your behalf, e.g. to receive test results or to discuss your medical care? If you do please fill in their details below		
Name	*Relationship to you*	*Telephone number*

Smoking					
Are you currently a smoker?	Yes	No	Have you ever been a smoker?	Yes	No
If so, how many cigarettes, cigars, or ounces of tobacco do you smoke a day?		If you are a smoker would you like help in quitting?		Y/N	

How much alcohol do you drink?

2 units
Pint of regular beer/ Lager or cider

1unit
Single measure of Spirits

2units
Glass of wine (175ml)

1.5units
Can of regular lager or alcopop

9 units
Bottle of wine

Questions	Scoring system 0	1	2	3	4	Your score
How often do you have a drink that contains alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4+ times a week	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

A total score of 5+ indicates harmful drinking
If you require advice regarding your alcohol consumption please speak with the nurse

Exercise				
How often do you exercise?	Never	1-3x/month	1-3x/week	Daily
What type of exercise do you do?				

Please list any allergies below, e.g. medication or foods

Ladies only		
Please give the date of your last cervical smear		
What contraception are you using – if you have a coil or the Nexplanon when is it due to be changed?	Name	Date

Carers		
Do you have a carer? If yes please give details	Y/N	Name Relationship to you Address Post Code Telephone number
Are you a carer? If yes please give details If yes have you registered for an annual flu vaccination?	Y/N Y/N	Name Relationship to you Address Post Code Telephone number
Are you happy for us to include you on our carers register?		Y/N
Would you like to be referred to Northamptonshire Carers for additional support?		Y/N

Veterans		
Are you a veteran?	Y/N	If yes - which branch of the services were you with?

Patient Participation Group	
The practice is committed to improving the services we provide to our patients. To do this, it is vital that we hear from people about their experiences, views and ideas for making the service better. By expressing your interest, you will be helping us to plan ways of involving patients that suit you. If you are interested in getting involved, please tick the box below	
Yes, I am interested in becoming involved with the Patient Participation Group	Y/N

Clinical Staff only

Height		Weight		Blood Pressure	

Urine Dip		Urine sent < 25 yrs	

Recalls	
Coil change	
Hypertension	
Influenza vaccine – surgery or home	
Nexplanon change	
Pill check	
Repeat blood test – add reason	
Thyroid blood test	

Reception Staff Only

ID Seen	Y/N	Type of ID	

Proof of Address seen	Y/N	Type of Proof	