The Island Surgery

NEW PATIENT QUESTIONNAIRE FOR ADULT

TWO FORMS OF ID ARE REQUIRED FOR REGISTRATION
ONE MUST CONFIRM YOUR DATE OF BIRTH AND THE OTHER YOUR CURRENT ADDRESS

Date form completed:	NHS Number (if known):

Patient Details

Forename(s):	Surname:
Date of Birth :	Previous Surname:
Sex: Male / Female	Contact Telephone Numbers Home: Mobile: Consent to be contacted by text message YES/NO (includes appointment reminders) Email:
Town of birth:	
Country of birth:	
First language spoken:	
Ethnic origin:	
Next of Kin	
First Name:	Surname:
Relationship:	Contact Telephone Numbers Home: Mobile:
Do you have carer that looks after you? YES/NO If Yes please provide details, Name: Contact Telephone Number:	**Are you a carer for someone?** YES/NO If Yes please provide details, Name: Contact Telephone Number:
Summary Care Record	
I understand that if I do not want a Summary Care Record I must complete an **OPT OUT FORM** (available from reception). If I do not complete an opt-out form a summary care record will automatically be created. This allows authorised clinicians providing me with emergency care to access information about my medication and any sensitivities or allergies I may have. (Please sign)……..	
We continually aim to improve our patient service, therefore we are interested to know your reasons for choosing The Island Surgery as your GP practice?	

PLEASE PROVIDE MEDICAL HISTORY OVERLEAF

FOR OFFICE USE ONLY:			
FORM OF ID SEEN TO CONFIRM DATE OF BIRTH:	*FORM OF ID SEEN TO CONFRIM ADDRESS:*	*FORM & QUESTIONNAIRE Signed:*	*SEEN BY:*

Please state any significant medical history :
eg Asthma/COPD/Diabetes/Heart conditions/Cancer/Glaucoma/Stroke or any other serious illness or operations

Are you currently on any repeat medication? YES / NO
If yes please give details:

Do you suffer from any allergies? YES / NO
If yes please give details:

Is there any significant family history? eg Asthma/Diabetes/Heart conditions/Cancer/Glaucoma/Stroke
If yes please give details:

What is your Smoking Status? Never Smoked / Smoker / Ex-Smoker

Are you currently receiving medical care at any other establishment? YES / NO
If yes please give details:

Are you receiving care from any other services? Eg Social Care, CAMHS: YES / NO
If yes, please give details :,

Does you have any disabilities? YES / NO
If yes, please give details:

Ladies Only:

Date of last smear test:	**Have you had a hysterectomy?** YES / NO If yes please give date: