Hillview Medical Centre
New Patient Questionnaire & Registration Form

PERSONAL DETAILS:	
Title	
Surname	
Forename	
Middle Name(s)	
Date of Birth	
NHS Number	
Gender	
Marital Status	
Previous Surname(s) (where applicable)	
Town & Country of Birth	
Ethnicity	☐ British ☐ African ☐ Bangladeshi ☐ Caribbean ☐ Chinese ☐ Indian ☐ Irish ☐ Other White ☐ Other Asian ☐ Other Black ☐ Other Mixed ☐ White Asian ☐ Pakistani ☐ W&B African ☐ W&B Caribbean ☐ Refuse to Divulge
Main Language	
Interpreter Required?	☐ Yes ☐ No
HOME ADDRESS:	
House Name\Flat Number	
Number & Street	
Locality	
Town	
County	
Postcode	
CONTACT DETAILS:	
Home Telephone	
Mobile Telephone	
Work Telephone	
Email Address	
PATIENT CONTACTS:	
Next of Kin	
Relationship	
Telephone Number	

PLEASE HELP US TRACE YOUR PREVIOUS MEDICAL RECORDS BY PROVIDING THE FOLLOWING:	
Previous address in the UK	
Name & Address of previous GP	
IF YOU ARE FROM ABROAD:	
Your first UK address where registered with a GP	
If previously resident in UK; date of leaving	
Date you first came to live in the UK	
IF YOU ARE RETURNING FROM THE ARMED FORCES:	
Address before enlisting	

Hillview Medical Centre
New Patient Questionnaire & Registration Form

Service or Personnel number	
Enlistment Date	
Date of leaving	

MEDICAL HISTORY:

Please list all current or past illnesses/operations including dates where possible:

☐ Heart Disease / Angina ☐ Diabetes ☐ Epilepsy
☐ High Blood Pressure ☐ Stroke/TIA ☐ COPD
☐ Asthma ☐ Cancer ☐ Hypothyroidism
☐ Osteoporosis ☐ Rheumatoid Arthritis ☐ Dementia
☐ High Cholesterol ☐ Other (please state):

Do you have any Allergies?(e.g. antibiotics, food, bee sting, latex,) ☐ YES ☐ NO

If Yes please state:

Immunisations; If known, please circle the immunisation received and complete the date if known;

	Date Received		Date Received
Pneumococcal		Polio	
Tetanus		Yellow Fever	
Typhoid		Hepatitis B	
Hepatitis A		MMR	

Ladies: Are you currently Pregnant? ☐ YES ☐ NO

If you are pregnant please provide estimated delivery date:

Have you had a smear test? If so when?

Have any close relatives ever suffered from: the following, please indicate which relative:-

☐Heart Disease ☐Diabetes
☐Asthma ☐High Blood Pressure
☐Dementia ☐Diabetes
☐Cancer – type.....☐Other

Drinking: Please complete the following questions

How often do you have a drink containing alcohol?	Never	Monthly or less	2 – 3 times per month	2 to 3 times per week	4 + times per 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	
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	
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	
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	
How often during the last year have you had a feeling of guilt or remorse after	Never	Less than monthly	Monthly	Weekly	Daily or almost	

drinking?					daily	
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	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
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	

CURRENT MEDICATION

If you have a repeat medication slip from your previous GP please attach to this form.

PRACTICE SERVICES\GROUPS:

Would you be interested in joining the Practice Patient Participation Group? ☐ YES ☐ NO

Carers: If you are a Carer please ask the receptionist for a yellow carers registration card so you can be added to the Practice's Register

Identifying Patients with Disabilities and other needs - Are you:

registered blind ☐ partially sighted ☐ registered deaf ☐ registered deafblind ☐ on the learning disabilities register ☐ have a visual impairment ☐ have hearing difficulties ☐ or use a hearing aids ☐

Do you have any information or communication needs when attending the surgery or receiving calls and letters from us?

Are you happy for these requirements to be shared with other healthcare professionals? Yes ☐ No ☐

Electronic Prescription Service: The practice can now send your prescription to your preferred pharmacy electronically. If you have previously nominated a pharmacy in another area and you now wish to change to a local pharmacy, please inform us of your preferred pharmacy:	

Signed:	
Date:	

Should you require any further information about the Practice please refer to the Practice Website: www.hillviewmedicalcentre.com or speak to Reception.

RECEPTION ONLY:

Type of ID Seen:	1. 2.
Seen by:	