**MANSFIELD MEDICAL CENTRE ADULT**

|  |
| --- |
| **Date** |

# New Patient Registration Form

Please complete this confidential questionnaire in full; if it is NOT completed correctly it will delay your registration. Please allow up to 14 days for the registration to be complete

Please complete in BLOCK CAPITALS and tick the boxes as appropriate.

If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.

Please complete a separate form for each family member to be registered.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **First Name:** | | | | | | | | | **Surname:** | | | | | | | | **Telephone Number:** | | | | | | | | | | | |
| **Mr / Mrs / Miss / Ms / Other……..** | | | | | | | | | | | | | | | | | **Work Number** | | | | | | | | | | | |
| **Full Address and Postcode** | | | | | | | | | | | | | | | | | **Mobile Number:** | | | | | | | | | | | |
| **E-mail Address:** | | | | | | | | | | | |
| **Next of Kin:** | | | | | | | | | | | |
| **Next of Kin Contact Number:** | | | | | | | | | | | |
| **Date of Birth:** | | | | | | | **Previous / Mother’s surname if different:** | | | | | | | | | | **Town & Country of Birth** | | | | | | | | | | | |
| **Marital Status:** |  | | | | | | **Gender:** | | | | | **Male:** | | | **Female:** | | **Other residents of your home:** | | | | | | | | | | | |
| **Occupation:** | | | | | | | | | | | | | | | | |
| **Names & Ages of Children** | | | | | | | | | | | | | | | | |
| **Housing**  **(Select one)** | | **House** | | | | | **Maisonette** | | | | | **Flat** | | | **Mobile Home** | | **NHS Number (If Known)** | | | | | | | | | | | |
| **Previous Address** | | | | | | | | | | | | | | | | | **Previous Postcode:** | | | | | | | | | | | |
| **Previous Doctor Telephone No.** | | | | | | | | | | | |
| **Previous Doctor Name & Address:** | | | | | | | | | | | | | | | | | **Previous data released?** | | | | | **Yes** | | | | | **No** | |
| **If applicable, date you**  **first came to live in Britain:** | | | | | | | | | | | |
| **If returning from**  **Armed Forces:** | | | | | | | **Your Service or Personnel Number** | | | | | | | | | | **Your Enlistment Date** | | | | | | | | | | | |
| **Your**  **height:** | | **Feet / inches** | | | | | | | | **cm** | | | | | **Your**  **weight:** | | **Stones / lbs.** | | | | | | **kg** | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Your**  **Religion:** | | **C of E** | | | | | **Catholic** | | | | | **Other Christian (state)** | | | | | **Buddhist** | | | **Hindu** | | | | | | **Muslim** | | |
| **Sikh** | | | | | **Jewish** | | | | | **Jehovah’s Witness** | | | | | **No religion** | | | **Other religion (state)** | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Your Ethnic Origin:**  **(select one)** | | | | | | | **White British/Mixed British** | | | | | | | | **Irish** | | | | | **White European** | | | | | | | | |
| **Caribbean** | | | | | | | **White & Black Caribbean** | | | | | | | | **African** | | | | | **Polish** | | | | | | | | |
| **Indian /**  **British Indian** | | | | | | | **Pakistani /**  **British Pakistani** | | | | | | | | **Other Asian**  **Background** | | | | | **Turkish** | | | | | | | | |
| **Other Black**  **Background** | | | | | | | **Chinese** | | | | | | | | **Lithuanian/Lativan** | | | | | **Ethnic Category**  **not stated** | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Your main or 1st language Spoken / Understood:**  **(select one)** | | | | | | | **English** | | | | | **Hindi** | | | **Gujurati** | | **Urdu** | | | **Bengali /Sytheti** | | | | | | **Punjabi** | | |
| **Polish** | | **Ukrainian** | | | | | **French** | | | | | **German** | | | **Spanish** | | **Other:**  **(Please**  **Specify)** | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Smoking, Alcohol Consumption and Exercise:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Are you currently a smoker?** | | | | | | | **Yes** | | | | | **No** | | | **Have you ever been a smoker?** | | | | | **Yes** | | | | | | **No** | | |
| **If so, how many cigarettes / cigars / tobacco do you smoke in a week?** | | | | | | | | | | | |  | | | **How much alcohol do you drink in a week (Units)?**  *(One unit = 1 small glass of wine, a single measure of spirits, or 1/2 a pint of beer)* | | | | | | | | | | |  | | |
| *If you are a smoker and want to stop, please ask for information about local smoking cessation services.* | | | | | | | | | | | | | | |
| **How often do you exercise?** | | | | | | | | | | **No. times per week** | | | | | | **Type(s) of exercise:** |  | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Your Medical Background:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **What illnesses have you had & When?** | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| **What operations have you had and When?** | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| **Do you have any medical problems at present?** | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| **Please list any tablets, medicines or other treatments you are currently taking:**  **(incl. dose + frequency)** | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| **Are you able to administer your own medicines?** | | | | | **Yes** | | | | | | | **No – please detail specific issues (e.g. swallowing, opening containers)** | | | | | | | | | | | | | | | | |
| **Are there any**  **serious diseases that affect your Parents, Brothers or Sisters**  **(tick all that apply)** | | | | | | **Diabetes** | | | | | | | **Heart Attack** | | | **Heart attack under age of 60** | | | | | **Bowel Cancer** | | | | | | | | |
| **Breast Cancer** | | | | | | | | | | **High Blood Pressure** | | | | | **Asthma** | | | | | | **Stroke** | | |
| **Thyroid Disorder** | | | | | | | | | | **Any other important Family Illness?** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **What immunisations have you had? (please tick all that apply)** | | | **Diphtheria** | | | | | **Measles** | | | | | **German Measles** | | | | | **Tetanus** | | | **Polio** | | | | | | **MMR** | | |
| **Whooping Cough** | | | | | | | | | | **Pre-school booster** | | | | | **Triple vaccine (Diphtheria,**  **Tetanus & Pertussis) –**  **3 doses** | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Specific Needs:**  **Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Please state any Sensory Impairment you have**  **(i.e. Speech, Hearing, Sight):** | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| **Are you an ‘Assistance Dog’ User?** | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| **Please state any requirements you have to be able to access the Practice premises** | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| **Please state any Religious or Cultural needs:** | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| **Do you require the help of a Translator / Interpreter?** | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| **Please state any specific nutritional requirements you have:** | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| **Please state any allergies and sensitivities you have:** | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| **Please state any phobias you have:** | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| **If you are a Carer, please state the name / address / phone number of the person you care for:** | | | | | | | | | | | **Person Cared For Contact Details:** | | | | | | | | | | | | | | | | | | |
| **If you have a Carer, please state their name / address / phone number and sign here if you wish us to disclose information about your health to your Carer.** | | | | | | | | | | | **Carer Contact Details:** | | | | | | | | | | | | | | | | | | |
| **Signed: Date:** | | | | | | | | | | | | | | | | | | |
| **Do you have a “Living Will”**  **(a statement explaining what medical treatment you would not want in the future)?** | | | | | | | | | | | **Yes / No** | | | ***If “Yes”,***  ***can you please bring a written copy of it***  ***to your New Patient Consultation*** | | | | | | | | | | | | | | | |
| **Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)?** | | | | | | | | | | | **Yes / No** | | | **If “Yes”, please state their name / address / phone number:** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Women only:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **When was your last smear done?** | | | | **Date** | | | | | | | | | **Was this at your**  **GP’s Surgery?** | | | | | **Yes** | | | | | | **NO** | | | | | |
| **What was the result**  **of the smear?** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| **Date of last mammogram**  **(if applicable):** | | | | | | | | **Date** | | | | | | **Method of contraception (if used):** | | | | |  | | | | | | | | | | |
| **Do you wish to see a doctor in this practice for contraceptive services (including the pill, coil or cap)?** | | | | | | | | | | | | | | | | | | **Yes** | | | | | | **NO** | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Summary Care Records.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | **Mansfield Medical Centre is supporting Summary Care Records and as a patient you have a choice if you DO NOT want a summary care record then please tick the box and ask at reception for a opt out form. You should do this even if you have already completed a form at your previous practice. You are free to change your decision at any time by informing the practice.** | | | | | | | | | | | | | | | | | | | | | | | **No** | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **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 services better.**  **By expressing your interest, you will be helping us to plan ways of involving patients that suit you.**  **It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice.**  **If you are interested in getting involved, please tick the box below and we will arrange for the Practice Patient Participation Group Application Form to be given to you at your initial consultation.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Yes, I am interested in becoming involved in the Practice Patient Participation Group (Please tick the “Yes” Box)** | | | | | | | | | | | | | | | | | | | | | | | **Yes** | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Patient**  **Signature:** | |  | | | | | | | | | | | | | | **Signature on**  **behalf of Patient:** | | |  | | | | | | | | | | |

***Your physical examination will include having your height, weight and blood pressure taken, and a specimen of urine for testing (it would be helpful if you would bring a specimen with you when coming to the Practice).***

***The Consultation will also establish relevant past medical and family history, including:***

* ***Medical factors - illnesses, immunisations, allergies, hereditary factors, screening tests, current health***
* ***Social factors - employment, housing, family circumstances***
* ***Lifestyle factors - diet and exercise, smoking, alcohol and drug abuse.***

**Thank you for completing this form**

***For more information about the services we offer, please refer to our website:***

***www.mansfieldmedicalcentre.nhs.uk***

**AUDIT-C QUESTIONNAIRE**

Name:…………………………………………………………………………. Date:……………………

D.O.B:………………...............

For the following questions please tick the answer which best applies.

*1 drink = ½ pint of beer or 1 glass of wine or 1 single of spirits*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. How often did you have a drink containing alcohol in the past year? | Never  □ 0 | Monthly or Less  □ 1 | Two to four times a month  □ 2 | Two to three times per week  □ 3 | Four or more times a week  □ 4 |
| 2. How many drinks did you have on a typical day when you were drinking in the past year? | 1 or 2  □ 0 | 3 or 4  □ 1 | 5 or 6  □ 2 | 7 or 9  □ 3 | 10+  □ 4 |
| 3. How often did you have six of more drinks on one occasion in the past year? | Never  □ 0 | Monthly or Less  □ 1 | Monthly  □ 2 | Weekly  □ 3 | Daily or almost Daily  □ 4 |
| Total for each column: |  |  |  |  |  |
|  |  | Total: |  |  |  |

MANSFIELD MEDICAL CENTRE

56 Binley Road

Coventry

CV3 1JB

Tel No: 02476 457551

HIV

WE CAN BEAT IT

GET TESTED, GET TREATED

As a new patient to our surgery we would like to invite you to have a routine HIV test.

HIV (Human Immunodeficiency Virus) is a virus that affects the immune system and causes AIDS. It may take years before damage is done to the immune system but needs to be diagnosed as early as possible.

Coventry has one of the highest HIV infection rates in the West Midlands with 3 in every 1,000 15-59 year olds in the city being HIV positive.

All of us may be at risk of HIV infection and no one can assume their HIV status without taking a test. We want people to know that HIV is a treatable condition, and people who are diagnosed early can have a near-normal lifespan. The treatment can be as simple as taking 1 tablet per day and is free.

The HIV test is a blood test that looks for the presence of antibodies in the blood that indicates whether or not you are infected with HIV.

The result may be negative or positive. If the result is negative it means you do not have HIV infection. If the result is positive it means that you have HIV antibodies in your blood and you have HIV infection. Sometimes the test can be uncertain (equivocal).

If your result is positive or equivocal we will contact you to give advice on your further management and treatment.

Taking an HIV test is confidential. The test results will appear only on your medical record. A negative test has no implications for insurances or mortgages.

We know that HIV is not something that people talk about openly, but we think HIV should be seen just like any other chronic condition, such as high blood pressure or diabetes, as something that can easily be treated.

We would strongly advise you to get tested and therefore, ask that you complete the section below to request a blood test form from reception. You need to take this form to one of the community pharmacies who undertake blood tests or go to University Hospital or Coventry City Health Centre.

For more information about local testing you can contact the Terence Higgins Trust by calling 02476 229292 or emailing info.coventry@tht.org.uk

|  |
| --- |
| Confidential HIV testing  Name:............................................................................. D/B...............................  Address:................................................................................................................  ..............................................................................................................................  I would like to have a blood test and would be obliged if you could –   * Arrange for me to pick up a blood test form – ring me on ................................................. when it is ready to collect * Please send me a blood test form in the post |