Pendleside Medical Practice

New Patient Registration

For Office Use	
Emis No:	
Appt:	

WELCOME TO THE PRACTICE

We would be grateful if you could make an appointment at reception to see the Health Care Assistant within 28 days of registering with the practice.

Your Details

First Name(s):	**Surname:**
Previous Name: (if applicable)	**Date of Birth:**
Address:	
PostCode:	**Email:**
Home Tel No:	**Mobile Tel No:**
The surgery has a text message service to remind you of upcoming appointments. If you would like to opt out of this service please tick here ☐	
Marital Status:	**Occupation:**
Ethnic Origin:	**First Language:**

Lifestyle

Do You Smoke?	Yes	No

If "Yes"

How many per day?		**In what form?**	Cigarettes	Cigars	Pipe
Would you like "stop smoking" advice?	Yes	No			

If "No"

Have you ever smoked?	Yes	No	**If "yes" how many per day?**		**When did you stop?**	

Do you exercise?	Yes	No
Please give details of regular exercise		

Do you drink alcohol?	Yes	No	**How many units per week?**	

Questions	0	1	2	3	4	Your Score
How often do you have 8 (for men), 6 (for women) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative/friend/doctor been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes during the last year	

Medical History

Do you consider yourself to be fit and well?	Yes	No
Do you suffer from any significant Illnesses?	Yes	No
If "yes" please give details:		

Current Medication

If you have a recent repeat medication slip, please bring this to your appointment

Allergies

Do you suffer from any allergies	Yes	No
If "yes" please give details:		

Immunisation & Vaccinations

Date of last Tetanus	
Date of last Polio	
Any others vaccinations, with dates:	

Next of Kin

Name:	**Relationship:**
Address: **Postcode:**	
Home Tel No:	**Mobile Tel No:**

Carers

Do you care for anybody	**Yes**	**No**	**If "yes" please give details of this person**	
Name:			**Relationship:**	
Would you like some information sending on our local cares link?			Yes	No
Do you have a medical condition that affects your ability to care?			Yes	No

Family History

Have any of your family suffered from any of the following (please state family member)

Heart Attack	Yes	No		**Stroke**	Yes	No	
High Blood Pressure	Yes	No		**Diabetes**	Yes	No	
Asthma	Yes	No		**Cancer**	Yes	No	

FOR WOMEN ONLY

Date of last smear		
Has it ever been abnormal?	Yes	No
If "yes" please give details:		
Do you have children?	Yes	No
If "yes" please give details:		

FOR CHILDREN UNDER 5

List all vaccination that your child has received to date.

If you wish to join our patient participation group, please ask at reception or go to our website www.pendleside.nhs.uk