**St Georges Surgery**

40 St Georges Crescent

Wrexham

LL13 8DB

01978 290 708

enquiries.w91030@wales.nhs.uk

**New Patient Registration (Adults)**

**About you**

Surname: Forename(s):

Date of Birth (dd/mm/yyyy):

NHS number (if known): [www.nhs.uk/find-nhs-number](http://www.nhs.uk/find-nhs-number)

**Which of the following best describes how you think of yourself?**

□ Female (including trans women)

□ Male (including trans men)

□ Non-binary

□ In another way (please state):

Is your gender identity the same as the gender you were given at birth?

□ Yes

□ No

**Which of the following options best describes you?**

□ Heterosexual/Straight

□ Lesbian/Gay

□ Bisexual

□ In another way (please state):

*Under the Equality Act 2010 and the Public Sector Equality Duty, all public organisations have a duty of care to pay due regard to patients with protected characteristics. For this reason, collecting a variety of demographic information enables healthcare providers to tailor the services and support they offer.*

**Contact Information**

**We will use your contact details to send reminders about appointments, reviews and other services which may be of benefit in your medical care**

Address:

Telephone: Mobile:

Email:

Please circle below your preferred choice of contact:

**Text Phone Email Post**

Do you live in a residential home? **Yes No**

Do you live in a nursing home? **Yes No**

Would you describe yourself as homeless? **Yes No**

What is your occupation?

**Residency**

Previous address in the UK (if applicable):

**Asylum Seekers**

Are you classed as an Asylum seeker? **YES NO**

If so, please indicate your country of origin:

**Ethnicity**

Having information about patients’ ethnic groups would be helpful for the NHS so that it can plan and provide culturally appropriate and better services to meet patients’ needs.

If you do not wish to provide this information you do not have to do so.

Please indicate your ethnic origin by ticking the below box:

|  |  |  |  |
| --- | --- | --- | --- |
| Welsh |  | Pakistani |  |
| British or mixed British |  | Bangladeshi |  |
| African |  | Chinese |  |
| Caribbean |  | Irish |  |
| Indian |  | Other (Please state) |  |

**Country of birth**

In which country where you born?

If you are from abroad, what date did you come to UK?

**Smoking status**

Do you smoke? **Yes No**

**If yes,** how many cigarettes do you smoke daily:

**If no,** have you smoked in the past? **Yes No**

Do you use electronic cigarettes/vape? **Yes No**

Do you use chewing tobacco **Yes** **No**

Do you use a Shisha

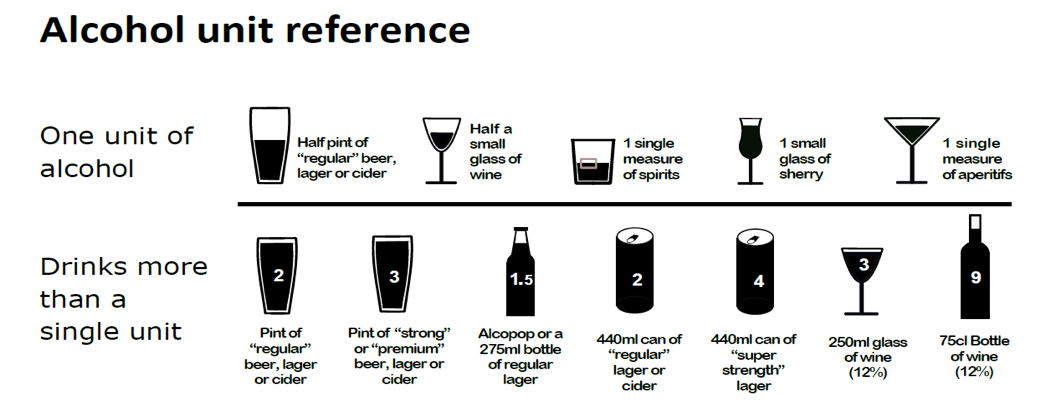
**Yes No**

**Smoking is the UK’s single greatest cause of preventable illness.**

*Stopping smoking is not easy but it can be done, and there is now a comprehensive, NHS Smoking Cessation Service offering support and help to smokers wanting to stop, with cessation aids available on NHS prescription.*

*If you would like help and advice on how to give up smoking, please contact* [*https://www.nhs.uk/live-well/quit-smoking/*](https://www.nhs.uk/live-well/quit-smoking/) *or ask at reception.*

**Alcohol intake**



|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Questions** | **Scoring system** | | | | | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink that contains alcohol? | Never | Monthly or less | 2-4 times per month | 2-3 times per week | 4+ times per week |  |
| How many alcoholic drinks do you have on a typical day when you are drinking? | 1-2 | 3-4 | 5-6 | 7-9 | 10+ |  |
| How often do you have 6 or more standard drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |

Scoring

Score: ……………….

*A total of 5+ indicates increasing or higher risk drinking. If you have a score of 5+ please complete the remaining questions below.*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Questions** | **Scoring system** | | | | | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| 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 |  |
| **Questions** | **Scoring system** | | | | | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| 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 drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost 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 |  |

Please add up your scores from the above tables and write the total below:

**Total**…………………………..

*If you would like help and advice on how to reduce your alcohol intake, please contact* [*https://www.drinkaware.co.uk/*](https://www.drinkaware.co.uk/) *or ask at reception.*

**Exercise**

**General Practice Physical Activity Questionnaire**

1. Please tell us the type and amount of physical activity involved in your work.

|  |  |  |
| --- | --- | --- |
|  |  | **Please mark one box only** |
| a | I am not in employment (e.g. retired, retired for health reasons, unemployed, fulltime carer etc.) |  |
| b | I spend most of my time at work sitting (such as in an office) |  |
| c | I spend most of my time at work standing or walking. However, my work does not require much intense physical effort (e.g. shop assistant, hairdresser, security guard, childminder, etc.) |  |
| d | My work involves definite physical effort including handling of heavy objects and use of tools (e.g. plumber, electrician, carpenter, cleaner, hospital nurse, gardener, postal delivery workers etc.) |  |
| e | My work involves vigorous physical activity including handling of very heavy objects (e.g. scaffolder, construction worker, refuse collector, etc.) |  |

**Height/Weight/ BP**

What is your height:

What is your weight:

Blood Pressure:

*If you would like advice on managing a healthy weight, please contact* [*https://www.nhs.uk/live-well/*](https://www.nhs.uk/live-well/) *or reception who will be able to direct you to the most appropriate service.*

**Disabilities / Accessible Information Standards\_**

**As a practice we want to make sure that we give you information that is clear to you. For that reason we would like to know if you have any communication needs.**

Do you have any special communication needs?

**Yes No**

**If yes,** please state your needs below:

**………………………………………………………………………………..**

Do you have significant mobility issues? **Yes No**

**If yes,** are you housebound? **Yes No**

*(Definition of housebound - A patient is unable to leave their home due to physical or psychological illness)*

Are you blind/partially sighted? **Yes No**

Do you have significant problems with your hearing? **Yes No**

**Service Families and Military Veterans**

As a practice, we fully support the Armed Forces Covenant. We can only do this if we know our patients’ connections to the Armed Forces. Please tick the below boxes that apply to you:

|  |  |  |  |
| --- | --- | --- | --- |
| **I AM** a Military Veteran |  | **I AM** currently serving in the Reserve Forces |  |
| **I AM** married/civil partnership to a serving member of the Regular/Reserve Armed Forces |  | **I AM** married/civil partnership to a Military Veteran |  |
| **I AM** under 18 and my parent(s) are serving member(s) of the armed forces. |  | **I AM** under 18 and my parent(s) are veteran(s) of the armed forces. |  |

**Main language**

Which is your main language?.................................................................

Do you speak English?.............................................................................

Do you need an interpreter? **Yes No**

If so, which language? …………………………………………

**Carer status**

Do you have a carer? **Yes No**

**If Yes, please give details of their name, relationship and whether they are a patient here too………………………………………………………………………………………………………..**

Do you give consent to contact your carer about your care?

Are you yourself a carer? **Yes No**

**Next of kin**

Surname: …………………………………… Forename(s): …………………………………………

Gender: …………………………………… Relationship…………………………………………….

**Emergency contact Information (for next of kin)**

Telephone: ……………………………………… Mobile: ……………………………………………

**Resuscitation wishes and Power of Attorney**

Do you have a DNACPR (Do not attempt CPR) form in place? **Yes No**

Does anybody hold Lasting Power of Attorney for Health and Welfare for you?

**Yes No**

If **YES to either of the above questions**, please supply details of who holds this and where (and supply a copy for your medical notes).

Details…………………………………………………………………………………………………………………….

**Family History and past medical history**

Have any close relatives (parent, sibling or child only) ever suffered from any of the following?

|  |  |  |  |
| --- | --- | --- | --- |
| Condition | Yes | No | Relationship |
| Heart Disease (Heart attack/Angina) |  |  |  |
| Stroke |  |  |  |
| Diabetes |  |  |  |
| Asthma |  |  |  |
| Cancer |  |  |  |

Have you yourself ever suffered from any important medical illness, operation or admission to hospital? **If so** please enter details below:

|  |  |  |
| --- | --- | --- |
| **Condition** | **Year diagnosed** | **Ongoing?** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Allergies**

Please list any drug or food allergies that you have:

………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

**Medications**

Please provide a list of repeat medications:

………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

**For female patients only**

Are you currently pregnant? **Yes No**

***If yes,*** *please ensure you are under the care of a midwife. If you’re not currently under the care of a midwife please speak to reception regarding this.*

Which method of contraception (if any) are you using at present?

**……………………………………………………………………………………**

Do you currently have long acting reversible contraception in place? *(Implant/Coil)*

**Yes No**

**If yes**, when was this fitted? (dd/mm/yyyy)

**…………………………………**

Have you had a cervical smear test? **Yes No**

**If yes**, when was this last done? (dd/mm/yy)

**……………………………………**

Have you had a hysterectomy? **Yes No**

Do you still have your ovaries? **Yes No**

**Donation wishes**

If you live in Wales, England or Jersey, are not in a group excluded from opt out legislation and you have not registered an organ donation decision, it will be considered that you agree to be an organ donor. This is known as deemed consent.

If you do not want to donate your organs then you should register your decision to refuse to donate. Remember to speak to your family and loved ones about your decision. To opt out, visit: <https://ardens.live/Organ-donation-opt-out>

Do you have a donor card or are you on the organ donation register? **Yes No**

Have you opted out? **Yes No**

Do you donate blood? **Yes No**

**Surgery confidentiality statement**

*We hold your patient records in the strictest confidence, regardless of whether they are electronic or on paper. We take all reasonable precautions to prevent unauthorised access to your records, however they are stored. Any information that may identify you is only shared with the practice team, or, if you are referred to hospital, to the clinician who will be treating you. We will only share information about you with anyone else if you give your permission in writing.*