

**Welcome to Princess Street Group Practice.**

Please carefully complete this registration form. Your answers will help us to plan services that can help to improve your health. If you have any problems completing this form please ask reception for help. We may have some questions to ask you regarding your answers so a member of the reception team will go through your completed form with you. We will then give you a copy of our practice leaflet and any other relevant information. The receptionist will also be able to help you if you need to book any appointments.

**PERSONAL DETAILS** (Please complete in block capitals and ✓ as appropriate)

**Family Name:** ..... **Former Family Name:** .....

**First Name:** ..... **Middle Name(s):** .....

**Title:** Mr  Mrs  Miss  Ms  Other  (please state).....

**Gender:** Male  Female  **Date of Birth:**.....

**NHS Number: (If known)**.....

**Current Address:** Flat Number..... Flat Name.....

House Number..... Road Name .....

**Postcode:**.....

**Home telephone:** ..... **Work telephone:** .....

**Mobile telephone:** .....

Please indicate (by ticking) which number you would prefer us to contact you on during the day  
The practice will send text message reminders to your mobile. If you prefer not to receive these please tick

**The next questions will help us to establish if you have any previous NHS medical records and assist us in tracing those records. Please give as much information as possible.**

**Place of Birth:** ..... **Year you first came to UK (if applicable):** .....

**If you were previously a resident in the UK, give the year you left:** .....

**Name of your previous GP in UK :** ..... **No previous GP in UK**

**Your last home address:** Flat Number.....Flat Name.....

House Number.....Road Name.....

Town/City.....Postcode.....

**Name of Next of Kin:**.....**Relationship to you:** .....

**Next of kin contact telephone:** .....**Next of kin town of residence:** .....

**Is your Next of Kin registered at this practice?** Yes  No

**Signature:** ..... **Date:**.....

**FOR PRACTICE USE ONLY**

<b>Computer Number:</b>	<b>Form checked by:</b>	<b>Information given:</b> SCR info <input type="checkbox"/> Practice Leaflet <input type="checkbox"/>	<b>Entered by:</b>	<b>Date entered:</b>
-------------------------	-------------------------	---	--------------------	----------------------

## 1. WHAT IS YOUR ETHNIC GROUP?

<input type="checkbox"/> Prefer not to state ethnic group				
<b>White</b>	<b>Mixed</b>	<b>Asian or Asian British</b>	<b>Black or Black British</b>	<b>Other ethnic group</b>
<input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> Other white	<input type="checkbox"/> White and Black Caribbean <input type="checkbox"/> White and Black African <input type="checkbox"/> White and Asian <input type="checkbox"/> Other mixed background	<input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Other Asian background	<input type="checkbox"/> Caribbean <input type="checkbox"/> African <input type="checkbox"/> Other Black background	<input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Any other

What is your first language? .....

Do you need us to book you an interpreter for your appointments?  Yes  No

## 2. YOUR MEDICAL HISTORY

Have you had or do you now have any of the following illnesses?

<b>Please tick the box if you have any of the following illnesses</b>	<b>Date of diagnosis</b>	<b>DETAILS</b>
Asthma		
Diabetes		
High Blood Pressure		
Heart Attack		
Stroke		
Cancer		
Underactive thyroid (hypothyroidism)		
Epilepsy		
Any Mental Health problems (e.g. depression, schizophrenia)		
Other important illnesses or operations		

### 3. FAMILY MEDICAL HISTORY

Please give us some information about your family

	Any serious illnesses?	If Yes, please describe	Age at onset	If they have died, what was the cause of death?	Age at death
Father	Yes/No				
Mother	Yes/No				
Brothers & Sisters	Yes/No				

### 4. MEDICATION

Are you on any regular medication? Yes/No

*If you have ticked YES please ask reception to book you an appointment to see a doctor before your next supply is due. We are unable to issue any prescriptions until you have discussed your medication with the GP. If you have Asthma please make an appointment with our Asthma Nurse for a review.*

Do you have any drug allergies Yes/No

If yes, please list what these are .....

### 5. YOUR HEALTH

What is your weight? .....What is your height? .....

*Regular exercise and a good diet help to keep your heart healthy. Ask us for advice.*

When did you last have your blood pressure measured? Date: \_\_\_\_\_

Do you know what your reading was? ...../..... or Normal  Abnormal

*If you are aged 45 or over you should have your blood pressure checked every 5 years. If your last blood pressure check was abnormal or if you cannot remember the result please make an appointment to see the Health Care Assistant to get it checked.*

Do you drink alcohol? Yes/No

If yes, how many units do you normally drink per week? .....  
(One unit = half a pint of beer or 1 glass wine or 1 single measure of spirits)

*More than 21 units per week for men and 14 for women can damage your health. Ask a doctor or nurse for more advice.*

To help us to provide you with further advice can you please answer the following questions about your alcohol use:

<b>Men:</b> how often do you have EIGHT or more drinks on one occasion. <b>Women:</b> How often do you have SIX or more drinks on one occasion?	Never <input type="checkbox"/>	Less than monthly <input type="checkbox"/>	Monthly <input type="checkbox"/>
	Weekly <input type="checkbox"/>	Daily or almost daily <input type="checkbox"/>	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never <input type="checkbox"/>	Less than monthly <input type="checkbox"/>	Monthly <input type="checkbox"/>
	Weekly <input type="checkbox"/>	Daily or almost daily <input type="checkbox"/>	
How often during the last year have you failed to do what was normally expected of you because of drinking?	Never <input type="checkbox"/>	Less than monthly <input type="checkbox"/>	Monthly <input type="checkbox"/>
	Weekly <input type="checkbox"/>	Daily or almost daily <input type="checkbox"/>	
In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?	No <input type="checkbox"/>	Yes on one occasion <input type="checkbox"/>	
	Yes, on more than one occasion <input type="checkbox"/>		

Do you currently smoke? Yes/No

If yes, how many cigarettes do you smoke every day? .....

Have you ever smoked? Yes/No

If so, how many did you smoke every day before you stopped? .....

***Tobacco smoking is the biggest cause of preventable illness and death. If you want help to stop please ask for an appointment with a smoking cessation advisor.***

## 6. CONTRACEPTION AND SEXUAL HEALTH

Do you use contraception? Yes/No

What do you use?      Condoms       Contraceptive pill       IUD/Coil       Implant   
                                  Diaphragm       Depo provera injection       Patch

***We offer a full range of contraception, including emergency contraception (the 'morning after' pill). Ask any of our doctors or nurses. 1 in 10 young people in Southwark have a sexually transmitted infection. Very often people do not know they are carrying this. If you would like to have a sexual health screen please ask our reception team. .***



**9. DONOR INFORMATION**

If you would like to donate blood and/or be an organ donor please complete the following and we can add your details to the registers. We are unable to do this unless you sign the relevant section(s).

**NHS Blood Donor Registration**

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.

Tick here if you have given blood in the last 3 years

**Signature confirming consent to blood donation**

*For more information, please ask for the leaflet on joining the NHS Blood Donor Register  
My preferred address for donation is: (only if different from above, e.g. your place of work)*

\_\_\_\_\_ Postcode: \_\_\_\_\_

**NHS Organ Donor Registration**

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death.

Please tick as appropriate

Kidneys  Heart  Liver  Corneas  Lungs  Pancreas  Any part of my body

**Signature confirming consent to organ donation**

*For more information, please ask for the leaflet on joining the NHS Organ Donor Register*

**THANK YOU FOR COMPLETING THIS FORM**

Your registration should take 3-5 days to process. If you need to make an appointment to see one of our team sooner than this, please speak to a member of the reception team who can book you an appointment. If you have not had a practice leaflet please ask for one at reception.

**FOR PRACTICE USE ONLY**

Computer Number	Entered by:	Date entered: