NEW PATIENT APPLICATION FORM – ST JOHNS MEDICAL CENTRE

To The Patient:

To register with the Practice please complete this application fully as possible. The information will help clinicians to make an initial assessment of your health which will help in your future treatment

Patient Details

Mr/Mrs/Miss/Dr Surname: …….. Forename(s): ……

Male / Female / Transgender Male / Transgender Female

NHS No: …… Date of Birth: …… Marital status: ……

Address: …….

Postcode: …….. Town and Country of Birth …….

Home tel: ……..…… Mobile: …….

Email address: ……..

*St Johns Medical Centre operates a text message reminder service and on-line appointment booking service. Please ensure you provide both your mobile telephone number and E-mail address should you wish to benefit from these services

Name & Address of Current School if registering a child under 16 years old

……

If under 16 yrs old who has parental responsibility: Mother / Father / Joint

Have you at any time been a looked at child (fostered or under the care of local authority)
Yes No

Ethnic Background/Origin: ……

Occupation:…….

First Spoken Language …….
Do you require access to interpretation services? Yes/No

CARERS

Are you a carer (a family member or paid helper who regularly looks after a child or a sick, elderly, or disabled person)? Yes/No

If yes, please ask a member of the Reception Team about Carers support

Do you have a carer? Yes/No

If “Yes”, would you like them to deal with your health affairs here? Yes / No
If yes, please provide full name and relationship to carer ……..

Health Information

Weight (approx): …….. Height: ……

SMOKING

Do you smoke? Yes / No

If Yes, how many:
Cigarettes per day ……..... Cigars per day ……..Ounces of tobacco per day ……

How old were you when you started smoking? ……..

Would you like support in stopping smoking? Yes/No

EX-SMOKERS

How old were you when you stopped smoking? ……
How much did you smoke per day? ……..

PASSIVE SMOKING

Are you exposed to smoke at work? Yes / No At home? Yes / No

ALCOHOL

For the following questions please circle the answer which best applies:

1 drink = 1/2 pint of beer or one glass of wine or 1 single spirits

Men: How often do you have EIGHT or more drinks on one occasion?

Never Less than monthly Monthly Weekly Daily or Almost Daily

Women: How often do you have SIX or more drinks on one occasion?

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

How often during the last year have you failed to do what was normally expected of you because of drinking?

Never Less than monthly Monthly Weekly Daily or Almost Daily

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 Yes on one occasion Yes on more than one occasion

DIET
Do you add salt to your food after cooking? Yes / No

Do you have a varied diet including milk, meat, vegetables and fruit? Yes / No

Has your Cholesterol been checked in the last 2 years? Yes / No

EXERCISE
Do you take regular exercise? Yes / No

If yes, what sort of exercise? ……

How many times per week? ……..

FAMILY HISTORY
Is there any of the following in your family *(father, mother, brother, sister)* before age of 65?

Heart Disease (heart attacks, angina) Yes / No Which family member? ……
Stroke? Yes / No If yes, which family member? …….
Cancer? Yes / No If yes, which family member? …… Site of Cancer……

MEDICATION
Please give details of any medication which you take (prescribed or otherwise):

Name of drug: …… Name of drug: …….
Dosage: ……Dosage: …….

Name of drug: …… Name of drug: ……
Dosage: ……Dosage: ……

ALLERGIES
Are you allergic to any substances or foods? Yes / No
If yes, please give details:
……

PAST MEDICAL HISTORY
Please give details of any hospital treatment as an in-patient, including dates:
……
……
……
Please give details of any treatment for any chronic medical conditions:

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……
……
……
..
Please give dates of any X-ray, MRI or CT scans, Mammogram, Ultrasound:
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……
……

IMMUNISATIONS
Dates of Triple/polio/HIB: …… MMR: ……
Date of last Tetanus: ……

FEMALE PATIENTS

Date of most recent cervical smear: ……..
Result of most recent smear: …….
Please give details of any complications in pregnancy:
……
……

DISABILITY

Do you have a disability? Yes/No
If yes, please provide full details:
……
……

Do you have any communication needs and/or information needs relating to disability, impairment or sensory loss? Yes/No
If yes, please provide full details:
……
……

GENERAL

Are there any other issues which cause you concern or advice you may wish on any other health problems? If yes, please give details below:
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……
……

PATIENT ON-LINE SERVICES

The Practice offers a range of patient on-line facilities, for example, booking of appointments, requesting repeat medication, access to medical record information. If you would like to register for this service please see a member of the Reception Team who will provide you with the necessary application form. Please note, proof of ID and address will be required.

Text Message Service Reminder/Health Campaigns

I consent to the Practice contacting me by text message for the purposes of appointment reminders, health promotions and general Practice information. I acknowledge that appointment reminders by text are an additional service and may not be sent on all occasions; responsibility for attending or cancelling appointments, as does keeping the Practice informed if my mobile telephone contact number changes, rests with myself. I can cancel the text message facility at any time by texting 'OPT OUT' to any message received or by contacting a member of the Reception Team. Text message are generated using a secure facility but are transmitted over a public network onto a personal mobile telephone.

*Should you not wish to receive any text messages from the Practice please tick the Opt Out box ☐

Signed:…….. Date: ……..

Thank you for completing your new patient questionnaire. The practice will advise you when you are registered.