

New Patient Registration

1. Your NHS number:

2. Please indicate which surgery you are most likely to use:

Cherry Street		Fulford Surgery		Heworth Green	
Lavender Grove		Park View		Priory Medical Centre	
Rawcliffe Surgery		Tang Hall Lane		Victoria Way	

Contacting You

Where possible we like to communicate electronically. This is faster, kinder to the environment, and allows us to direct more resources into delivering clinical care.

3. Your personal mobile number: _____

4. Your personal email address: _____

Please tick if you **do not** wish to be contacted via text messaging (SMS)

Please tick if you **do not** wish to be contacted via e-mail

(Please ask the Receptionist if you would like to see a copy of our Privacy Policy)

5. Please tell us where you heard about Priory Medical Group (e.g. Friends, Google, NHS Website, Family, Yellow pages) _____

About your family medical history

6. BEFORE the age of 60, has one of your close relatives (Mother, Father, Brother or Sister) suffered from a:

Heart attack: No Yes Stroke: No Yes

About you and your medical history

7. Height

Weight

____ ft ____ ins or ____ cm	____ st ____ lb or ____ kg
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8. Do you have a nominated pharmacy? Yes No

If yes, please provide details here:

If you don't have a nominated pharmacy would you like Priory Pharmacy to deliver your medications? Yes No

9. Describe yourself: a smoker? never smoked? an ex-smoker?

10. My ethnicity is code _____ , or I **do not** wish to state my ethnicity

(The Department of Health require us to ask you about your ethnicity. The Receptionist will provide you with a list of ethnicity codes)

11. My first spoken language is _____

12. Have you previously been registered with the practice? Yes No

NHS Summary Care Record

Your NHS electronic Summary Care Record (SCR) contains important information about your health. NHS doctors and nurses treating you anywhere other than at your doctor's surgery may ask if they can look at this information to help them treat you quickly and safely, as they won't necessarily know about what has happened to your health in the past. If they do not know about your previous care, your SCR can help people caring for you to:

- Avoid errors, because they can see your medications, allergies or which medicines make you ill
- Make better and safer decisions on how best to treat you

You can choose to have other information added to your SCR which will enhance the care you receive from Doctors and Nurses. This information includes:

- Any illnesses and any health problems you have had
- Operations, medical procedures and vaccinations you have had
- How you would like to be treated
- What support for your care you might need
- Who should be contacted for more information about the care you need

If you would like this information adding to your SCR then please complete the following information.

Signed: _____ Date: _____

Signed for (if Parent/Legal Guardian): _____

Alternatively if wish to opt out of the NHS Summary Care Record completely, and not share your GP record information with other NHS doctors and nurses, then please tick this box:






13. Alcohol

Please complete the alcohol questionnaire on the next page. Depending on your score, you may be offered an appointment with a doctor.

Forename:

Surname:

Date:

UNITS	 2	 1	 9	 2	 1.5
	Glass of Wine (175ml)	Single Measure of Spirits	Bottle of Wine	Pint of Regular Beer/Lager/Cider	Alcopop or Can of Lager

How many units per week do you drink?
I never drink alcohol

AUDIT C

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 standard alcoholic drinks do you have on a typical day when you are drinking?	1 – 2 (score 0)	3 – 4 (score 1)	5 – 6 (score 2)	7 – 9 (score 3)	10+ (score 4)	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
TOTAL						

Scoring: If your total score is 5 or more, please complete the following questions

AUDIT

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often in the last year have you found you were not able to stop drinking once you had started?	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	
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you had a feeling of guilt or regret after drinking?	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	
Have you or someone 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/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	
TOTAL (including Audit C total)						

Thank you for your help. Please return your completed questionnaire to the surgery.