

WOOLSTON LODGE SURGERY CONFIDENTIAL

Please complete in FULL using BLOCK CAPITALS

Have you registered with this Practice before?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you had any serious illness, operations or abnormal test results in the past?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>		If yes, please give details:	
Title:		Are you currently under the care of any specialists? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes please give details: Please list any regular medication that you are taking: Are you allergic to any medications? (Please state the drug and the reaction suffered, with a date if known) Do you have any other allergies? E.g. Nut/food Do you have any family history that we should be aware of: If yes, please state condition and family member. Would you like to register for Online Services at the Practice? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Surname:			
Forename:			
Previous Surname (s):			
Date of Birth (Day/Month/Year):			
Address:			
Postcode:			
Home Telephone No:			
Mobile Telephone No:			
Are you a carer?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Do you have a carer?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Next of Kin – Please supply name, relationship and telephone number:			
If considered necessary by a health care professional, may we contact your next of kin?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Do you smoke?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
If so, how much?	Per Day		
Are you an ex-smoker?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
If so, what date did you give up?			
How much alcohol do you drink in an average week?			

FAMILY DOCTOR SERVICES REGISTRATION

The following information is required by the Health Authority to complete your registration.

Surname											
Forenames (in full please)											
Date of birth (Day/Month/Year)	<table style="width: 100%; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table>			/			/				
		/			/						
Your NHS number (if known)	<table style="width: 100%; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table>										
Your previous surname (if applicable)											
Town & country of birth											

Please help us trace your previous medical records by providing the following information

Your previous address in the UK (e.g. home or parental address) PLEASE INCLUDE THE POSTCODE	
Name of previous doctor while at that address	
Address of previous doctor	

If you are from abroad

Your first UK address where registered with a GP	
If previously resident in the UK, date of leaving	
Date you first came to live in the UK	

If you are returning from the Armed Forces

Address before enlisting	
Service or personnel number	
Enlistment date	

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: _____ Date: _____

If you are registering a child under 5

I wish the child named overleaf to be registered with Woolston Lodge Surgery for Child Health Surveillance

Please tick:

- Signature of patient
 Signature on behalf of the patient

Signature:	Date: (day/month/year)
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We would like to ensure our services are appropriate to everyone's needs, therefore we would be grateful if you could complete the following form. This form is optional and you are under no obligation to complete it.

What language do you speak?

Do you require a Interpreter?

What is your religion?

What is your ethnic origin - please tick one of the following boxes:

British	<input type="checkbox"/>	Indian	<input type="checkbox"/>	Caribbean	<input type="checkbox"/>
Irish	<input type="checkbox"/>	Bangladeshi	<input type="checkbox"/>	African	<input type="checkbox"/>
Other White	<input type="checkbox"/>	Pakistani	<input type="checkbox"/>	Other Black	<input type="checkbox"/>
White & Black Caribbean	<input type="checkbox"/>	Other Asian	<input type="checkbox"/>	Chinese	<input type="checkbox"/>
White & Black African	<input type="checkbox"/>			Any Other	<input type="checkbox"/>
White & Asian	<input type="checkbox"/>			Please explain:	
Other Mixed	<input type="checkbox"/>				

Alcohol Questionnaire (AUDIT C 9k17)

Please complete by ticking relevant answer

Q1 How often do you have a drink that contains alcohol?

- Never (0 points)
- Monthly or less (1 point)
- Two to four times a month (2 points)
- Two to three times per week (3 points)
- Four or more times per week (4 points)

Q2 How many standard alcoholic drinks do you have on a typical day when you are drinking?

- 1 or 2 (0 points)
- 3 or 4 (1 point)
- 5 or 6 (2 points)
- 7 to 9 (3 points)
- 10 or more (4 points)

Q3 How often do you have 6 or more standard drinks on one occasion?

- Never (0 points)
- Less than monthly (1 point)
- Monthly (2 points)
- Weekly (3 points)
- Daily or almost daily (4 points)

Total Score: _____

If total score is 5 or higher, please complete more detailed questionnaire overleaf.

To be completed if you score a total of five or above on the previous page.

Q4 How often in the last year have you found you were not able to stop drinking once you had started?

- Never (0 points)
- Less than monthly (1 point)
- Monthly (2 points)
- Weekly (3 points)
- Daily or almost daily (4 points)

Q5 How often in the last year have you failed to do what was expected of you because of drinking?

- Never (0 points)
- Less than monthly (1 point)
- Monthly (2 points)
- Weekly (3 points)
- Daily or almost daily (4 points)

Q6 How often in the last year have you needed an alcoholic drink in the morning to get you going?

- Never (0 points)
- Less than monthly (1 point)
- Monthly (2 points)
- Weekly (3 points)
- Daily or almost daily (4 points)

Q7 How often in the last year have you had a feeling of guilt or regret after drinking?

- Never (0 points)
- Less than monthly (1 point)
- Monthly (2 points)
- Weekly (3 points)
- Daily or almost daily (4 points)

Q8 How often in the last year have you not been able to remember what happened when drinking the night before?

- Never (0 points)
- Less than monthly (1 point)
- Monthly (2 points)
- Weekly (3 points)
- Daily or almost daily (4 points)

Q9 Have you or someone else been injured as a result of your drinking?

- No (0 points)
- Yes, but not in the last year (2 points)
- Yes, during the last year (4 points)

Q10 Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?

- No (0 points)
- Yes, but not in the last year (2 points)
- Yes, during the last year (4 points)

Total Score: _____