

MOREDON MEDICAL CENTRE

NEW REGISTRATION QUESTIONNAIRE FOR ADULTS

CONFIDENTIAL

YOUR NAME AND DETAILS	SURNAME: FIRST NAMES: PREVIOUS NAMES: DOB: NHS NO: TELEPHONE NUMBERS: Home: Mobile: Email address: I am happy to be contacted by the practice electronically? Yes No	
	Height	Weight

ETHNICITY LANGUAGE AND DISABILITY	ETHNIC GROUP (Please tick)		MAIN LANGUAGE (Please Tick)		DISABILITY (Please Tick)	
	British	<input type="checkbox"/>	English	<input type="checkbox"/>	Registered Blind	<input type="checkbox"/>
	Irish	<input type="checkbox"/>	Arabic	<input type="checkbox"/>	Partially Sighted	<input type="checkbox"/>
	Other White	<input type="checkbox"/>	Bengali	<input type="checkbox"/>	Deafness	<input type="checkbox"/>
	White British Caribbean	<input type="checkbox"/>	Cantonese	<input type="checkbox"/>	Uses Wheelchair	<input type="checkbox"/>
	White British African	<input type="checkbox"/>	Gujarati	<input type="checkbox"/>	Uses Zimmer Frame	<input type="checkbox"/>
	White Asian	<input type="checkbox"/>	Hindi	<input type="checkbox"/>	Stick For Walking	<input type="checkbox"/>
	Other Mixed	<input type="checkbox"/>	Mandarin	<input type="checkbox"/>		
	Indian British	<input type="checkbox"/>	Polish	<input type="checkbox"/>		
	Pakistani British	<input type="checkbox"/>	Portuguese	<input type="checkbox"/>		
	Bangladeshi British	<input type="checkbox"/>	Punjabi	<input type="checkbox"/>		
	Other Asian	<input type="checkbox"/>	Urdu	<input type="checkbox"/>		
	Caribbean	<input type="checkbox"/>	World Languages (please state)	<input style="width: 100px;" type="text"/>		
	African	<input type="checkbox"/>				
	Other Black	<input type="checkbox"/>				
Chinese	<input type="checkbox"/>					

SMOKING	Do You Smoke?	YES (how many?)	NEVER	EX-SMOKER
	If you are a smoker and would like help in giving up please contact our smoking cessation advisor on 01793 602885 or NHS Smoking Helpline 0800 1690169			

ALCOHOL	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 a 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	3-4	5-6	7-8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Please turn page over

MEDICAL INFORMATION	Do you have any allergies? Please list
	Are you taking regular medication? Please list
	Please list any health problems you have.
	Has anyone in your family suffered from diabetes, heart problems, high blood pressure, cancer or any other serious health problems? Please list and whom it was mother, father, brother, sister, grandmother or grandfather so on.

OTHER PEOPLE	Are you a Carer? If yes who for?
	Do you wish another person to be able to speak on your behalf about your health? If so please list.
	Signature: _____ Date: _____