



Downing Street Group Practice

4 Downing Street, Farnham, Surrey, GU9 7PA
Tel: 01252 716226 Fax: 01252 717076

NEW PATIENT PRACTICE REGISTRATION & HEALTH CHECK FORM

Please ensure you also complete the required NHS New Patient Registration Form

Dear Patient,

Welcome to the practice.

Please answer the following questions. It is essential that your new Doctor has some basic information about you as it can take some weeks for your previous records to arrive. Please make an appointment for a health check with the Practice Nurse. It is also an opportunity to discuss health issues and screen for potential problems eg cholesterol, diabetes and high blood pressure.

This examination is not necessary for children under 5 years of age.

Date of Registration

Surname First Name

Address PostCode

Date of Birth Home Tel Number Work/Mobile.....

Present Occupation (previous is retired or not working)

Marital Status Weight Height

ETHNICITY - Please circle the appropriate ethnic group.

- | | | | | | |
|---|---------------------|---|-------------------|---|-----------------|
| A | BRITISH | B | IRISH | C | ANY OTHER WHITE |
| D | WHT & BLK CARIBBEAN | E | WHT & BLK AFRICAN | F | WHITE & ASIAN |
| G | ANY OTHER MIXED | H | INDIAN | I | PAKISTANI |
| J | BANGLADESHI | K | ANY OTHER ASIAN | L | CARIBBEAN |
| M | AFRICAN | N | ANY OTHER BLACK | O | CHINESE |

Do you care for anyone who is chronically ill? **Yes / No** If yes, who do you care for?

You must make an appointment with a Doctor/Nurse Practitioner if you are on any medication before a prescription can be issued and please bring your medication with you.

SMOKING HISTORY

Are you a current smoker? **Yes / No** If yes, how many per day? Would you like help to stop? **Yes / No**

Are you an ex-smoker? **Yes / No** When did you stop? Never smoked (tick if appropriate)

ALCOHOL

How much alcohol do you consume per week?

DO YOU SUFFER FROM ANY ALLERGIES? Yes / No

Drug allergy (please specify)

Non drug allergy

Remember, you MUST make an appointment with your new doctor if you are on any medication.



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ABOUT YOU AND YOUR FAMILY

HAVE ANY FAMILY RELATED MEMBERS SUFFERED FROM ANY OF THE FOLLOWING?

Condition

Relation

At What Age?

Alive / Dead

Heart Attack

Angina

Other Heart Problem

(Please specify)

Diabetes

Asthma

Cancer

High Blood Pressure

Epilepsy

REGISTRATION CHECK - MAKE AN APPOINTMENT NOW AS THE CHECK NEEDS TO BE DONE IN THE NEXT 6 WEEKS.

Non-Discrimination Policy

Please note that the practice **does not** discriminate on the grounds of race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition.

REQUEST

PLEASE COULD NEW PATIENTS DELIVER THEIR FORMS IN PERSON WITH IDENTIFICATION OF A PASSPORT AND A UTILITY BILL.

ALSO, IT HELPS RECEPTION IF NEW PATIENTS COULD ATTEND IN THE AFTERNOON IF POSSIBLE.

THANK YOU



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AUDIT Screening Tool

Name _____

Date of Birth _____

	AUDIT Questions	Scoring system					Your score
		0	1	2	3	4	
AUDIT-C Questions 1-3 (code 38d4)	1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
	2. How many units of alcohol do you drink on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 9	10	
	3. How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
AUDIT - C SCORE If score is 5 or more continue with Questions 4 - 1							
AUDIT Questions 1-10 (code 38d3)	4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
	5. How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
	6. How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
	7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
	8. 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	
	9. Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
	10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
TOTAL AUDIT SCORE							

If your Total Audit Score is 8 or more, we would like to contact you to find out what assistance we can provide to bring your alcohol consumption to safer levels.

Thank you for completing this questionnaire and handing it to reception.