

# Capelfield Surgery

## New Patient Registration Form

Please complete this form in full using CAPITAL LETTERS and return to reception

\* denotes all required information

### SECTION A: TO BE COMPLETED BY ALL PATIENTS

First Name(s)*:		Surname*:		Title:
Marital Status: Married / Single / Other (Delete where necessary)			Male: <input type="checkbox"/>	Female: <input type="checkbox"/> (Please tick)*
Address:			Postcode:	
Date of Birth*: DD / MM / YYYY		Nationality*:		
Mobile Number*: 07			Home Tel*:	
Work Tel:			Occupation:	
Main Spoken Language*:		Height*:		Weight*:
<b>Ethnicity*:</b> White - British <input type="checkbox"/> Irish <input type="checkbox"/> Other..... (please state) Mixed - White/Black Caribbean <input type="checkbox"/> White/Black African <input type="checkbox"/> White/Asian <input type="checkbox"/> Other Mixed ..... (please		Asian or Asian British - Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Black or Black British- Caribbean <input type="checkbox"/> African <input type="checkbox"/> Other Ethnic Group - Chinese <input type="checkbox"/> Other .....(please state)		
<b>Family History*:</b> (Please tick if you have a family history of any of the following conditions)				
Asthma		Breast Cancer		
Diabetes		Heart Disease		
Glaucoma		Stroke		
High Blood Pressure		High Cholesterol		
Are you allergic to any medication*? (please state)				
Do you have any health problems and are you receiving hospital treatment*? (please give brief details )			Please list any medication that you are currently taking* (please state)	

### SECTION B: TO BE COMPLETED BY ADULTS AND CHILDREN ABOVE 14 ONLY

Do You Smoke*?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	(Please tick)	Never <input type="checkbox"/>
If yes, how many cigarettes* do you smoke per day? 1-9 <input type="checkbox"/> 10-19 <input type="checkbox"/> 20-39 <input type="checkbox"/> 40+ <input type="checkbox"/>				
Would you like help to give up smoking? Yes <input type="checkbox"/> No <input type="checkbox"/>				
If you are an ex-smoker, please state the approximate date when you gave up smoking. <input style="width: 100px;" type="text"/>				
How many cigarettes did you smoke per day? <input style="width: 100px;" type="text"/> *Cigarettes = any tobacco product (pipes etc)				

**Do You Drink Alcohol\*?** Yes  No

If YES, average units per week (1 unit = 1 glass of wine/1measure of spirits/half a pint of beer)

**PLEASE COMPLETE THE ALCOHOL QUESTIONNAIRE**

**FOR WOMEN ONLY:** If you are unsure of these dates, please leave blank.

When was your last cervical smear test?  Have you had a hysterectomy\*? Yes  No

Have you had a mammogram? Yes  No  If yes, please give the date:

**SECTION C: TO BE COMPLETED FOR CHILDREN ONLY\***

**VACCINATIONS:** Please complete all details as accurately as possible, if unsure, please refer to your child's **RED BOOK**.  
If you have lost your red book, please contact your previous GP surgery for a print out of your child's vaccination record (This is usually provided for free)

Please complete ALL SECTIONS and indicate which vaccinations your child has had AND the date that they were given:

<b>2 Months Old:</b> DTaP/IPV/Hib and Pneumococcal conjugate vaccine (PCV)	Date Given: DD / MM /YYYY	<b>3 Years and 4 Months or soon after:</b> DTaP/IPV or dTAP/IPV & MMR	Date Given: DD / MM /YYYY
<b>3 Months Old:</b> DTaP/IPV/Hib and MenC	Date Given: DD / MM /YYYY	<b>13-18 Years Old:</b> Td/IPV	Date Given: DD / MM /YYYY
<b>4 Months Old:</b> DTaP/IPV/Hib, MenC and PCV	Date Given: DD / MM /YYYY	<b>Girls Only:</b> HPV	Date Given: DD / MM /YYYY
<b>Around 12 Months Old:</b> Hib and MenC	Date Given: DD / MM /YYYY	<b>Non Routine Vaccines:</b> Hep B	Date Given: 1st: DD / MM /YYYY 2nd: DD/ MM /YYYY 3rd: DD/ MM /YYYY
<b>Around 13 Months Old:</b> MMR and PCV	Date Given: DD / MM /YYYY	<b>Non Routine Vaccines:</b> BCG	Date Given: DD / MM /YYYY

**Previous Illnesses:** (Please tick if your child has suffered from any of the following)

<b>Asthma</b>	<input type="checkbox"/>	<b>Heart Problems</b>	<input type="checkbox"/>
<b>Eczema</b>	<input type="checkbox"/>	<b>Chicken Pox</b>	<input type="checkbox"/>
<b>Epilepsy</b>	<input type="checkbox"/>	<b>Other</b> (please state)	<input type="text"/>

**Any other information that you feel relevant concerning your child:**

**SECTION D: DECLARATION to be signed by all patients/guardians**

I declare to the best of my knowledge that the information provided is correct.

**SIGNED:** ..... **DATE:** DD / MM / YYYY

**PATIENT / PARENT / GUARDIAN** (delete where appropriate)