WELCOME TO THE PANTON PRACTICE

PLEASE BE AWARE BEFORE REGISTERING - WE DO NOT PRESCRIBE ANY BENZODIAZEPINES (new or existing)

- Please Complete **both sides** of this form, writing clearly and in **BLOCK CAPITALS.** All information you give is confidential and will be held on your medical records
- Please use the machine in reception to measure height, weight and blood pressure and attach to this form.

YOUR DETAILS

First name:			
Middle name:			
Family/surname:			
Date of birth: (DAY/MONTH/YEAR)		Phone number:	
Address:			
Email:			
We may occasionally communicate with you by SMS or email, usually to remind you of appointments or health messages. We will not pass your email address or phone number to any non-NHS organisation. Tick here if you do **NOT** wish to be contacted by email or SMS. ☐			

EMERGENCY CONTACT/NEXT OF KIN

Full Name:			
Their relationship to you:		Date of birth: (DAY/MONTH/YEAR)	
Phone number:		Are they also registered with us ?	**YES / NO**

SUMMARY CARE RECORD

Please read attached information sheet before answering the following question. Please select one box only

SCR Consent	☐ Express consent for medication, allergies and adverse reactions only
	☐ Express consent for medication, allergies, adverse reactions and additional information
	☐ Express dissent – Does not want a Summary Care Record ***(please also sign separate disclaimer for this)***
Sign here:	

ETHNICITY

Your country of birth:		Date you first entered country:	
Your first language:		How would you describe your Ethnic group?	

FURTHER INFORMATION

Employment status:	☐ Employed ☐ Self-employed ☐ Unemployed ☐ Homemaker ☐ Student ☐ Retired
What is your current occupation if you have one?	
Are you a Military Veteran?	☐ Yes ☐ No

SMOKING please tick the box that applies to you	☐ I am a SMOKER How many Cigarettes per day? _____ ☐ I am an EX-SMOKER When did you stop smoking? _____ ☐ I have NEVER SMOKED

ALCOHOL 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 ☐ 3 – 2 ☐ 5 – 6 ☐ 7 – 9 ☐ 10+ *One standard drink is: 1 single measure of spirits, 1 small glass of wine, half a pint of beer, lager, or cider. A bottle of wine is 9 units*
How often do you have 6 or more standard drinks on one occasion?	☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily
EXERCISE Do you take exercise that lasts for at least 20 minutes per session?	☐ Yes If Yes, how many times a week? ☐ 1 ☐ 2 ☐ 3+ ☐ No

NOMINATED PHARMACY

Which Pharmacy do you use? (e.g Boots in the square)	
Would you like your prescriptions to be sent to them electronically? (You will need to register with the pharmacy for this)	☐ Yes ☐ No
OR If you would like to collect your prescriptions from the Surgery yourself, which surgery would you prefer?	☐ Gervis Road ☐ St Leonard's Road

MEDICAL HISTORY

Please list with dates any ***significant*** (chronic or acute) current or past illnesses, operations and especially **allergies**

SIGNIFICANT CHRONIC ILLNESS, OPERATION AND/OR ALLERGIES	DATE
Do you have any communication needs? (eg. documents in large print, sign language interpreter, use of our hearing aid loop. if so, please know if we can help you)	☐ Yes ☐ No Details:

* IMPORTANT - IF YOU TAKE REGULAR MEDICATION – PLEASE LIST BELOW *	
MEDICATION	**DOSE**

FAMILY HISTORY

Have any close family (parents/brother/sister) had any of the following illnesses or conditions below?

MEDICAL CONDITION (please tick)	**DETAILS** (Father, Mother, Sister and type of cancer/diabetes)
☐ Raised cholesterol	
☐ Stroke	
☐ Heart disease before the age of 60	
☐ Heart disease after the age of 60	
☐ Asthma	
☐ Cancer	
☐ Diabetes	

CARER/HOUSEBOUND INFORMATION

Are you housebound?	☐ Yes ☐ No		
Do you have a Carer?	☐ Yes ☐ No		
Name of your Carer:		Carers phone number:	
Are you a Carer?	☐ Yes Name of person you care for : _____ ☐ No		

WOMEN ONLY

Are you pregnant?	☐ Yes If Yes, when is your baby due? _____ ☐ No
What type of contraception do you use, if any? (**If coil or implant please include date it was inserted)**	

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

Issuing of the registration documents does not guarantee registration with this Practice

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FOR OFFICE USE ONLY:

PATIENT ENTITLED TO SECONDARY CARE ? : ☐ Yes ☐ No **PATIENT ADVISED ? :** ☐ Yes ☐ No

Does patient have European Health Insurance card (EHIC – S1 or S2)? ☐ Yes ☐ No

PROOF OF ID SEEN (please tick)	**STAFF NAME**	**DATE**
☐ Passport		
☐ ID card		
☐ Birth certificate		
☐ Driver's license		
☐ Other (please state):		

PROOF OF ADDRESS SEEN (please tick)	**STAFF NAME**	**DATE**
☐ Utility Bill		
☐ Bank statement		
☐ Driver's license		
☐ Other (please state):		