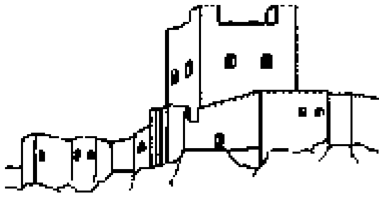
Date of Registration:	
EMIS Number:	Your Initials:



The Castle Practice (May 2019 version)

New Patient Registration Questionnaire

Please complete all sections of this form in their entirety
The completion of this form is essential for our records.

SECTION A - PERSONAL DETAILS:

PLACE OF BIRTH:

NAME:	**DOB:**
	H&C No:
ADDRESS	**PREVIOUS ADDRESS**
ARE YOU REGISTERING FROM OUTSIDE OF THE UK? **YES/NO** (Reception - if Yes - Form HSCR1 needed)	
HOME TELEPHONE NO:	**MOBILE NO:**
WORK NO:	**EMAIL ADDRESS:**
PREVIOUS GP DETAILS: Name and Address	Have you registered with the Castle Practice Before? Yes/No Have you ever been registered within the UK? Yes/No First Language:

ETHNIC ORIGIN - Please circle accordingly			
White	**Asian or Asian British**	**Mixed**	**Black or Black British**
British	Indian	White and Black Caribbean	Caribbean
Irish	Pakistani	White and Black African	African
Other	Bangladeshi	White and Asian	Other
	Other	Other	

Chinese or other Ethinc group	**Not Stated or Other**
Chinese	
Other	

SECTION B - HEALTH STATUS INFORMATION

SMOKING STATUS - Have you ever smoked?	**Yes/No**
If Yes, are you a current smoker?	**Yes/No**
How many do you smoke daily?	
ALCOHOL STATUS - Do you drink alcohol?	**Yes/No**
If Yes, how many units would you drink per week?	

P.T.O.

The Castle Practice

Date of Registration:		
EMIS Number:	Your Initials:	

New Patient Registration Questionnaire

SECTION C - MEDICAL HISTORY

Do you suffer from -	Condition	
	Asthma	Yes/No
	Heart Disease	Yes/No
	Diabetes	Yes/No
	Stroke	Yes/No
	Epilepsy	Yes/No
	COPD/Bronchitis	Yes/No
	Thyroid Problems	Yes/No
	High Blood Pressure	Yes/No
	Any other significant medical condition?	Yes/No

If you answered Yes to any of the above, please list your current medication

Medication	Strength	Dose

Castle Practice participates in the Department of Health led Benzodiazepines Reduction and Opiodes Reduction programme.
Patients should be aware that prescriptions and medications will be reviewed in line with the Department of Health Guidelines.

PLEASE TICK HERE TO CONFIRM YOU HAVE READ THIS NOTICE ☐

ALLERGIES - Please list any known allergies you have to medication (ie penicillin)

____

____

VACCINATIONS - Please list any know vaccinations received in the last 10 years

____

____

WOMEN ONLY - When was your last cervical smear? Date: ______________

If you are currently being prescribed contraception, please circle accordingly:

IUD (coil) Pill Depo-Provera Injection Implanon

For completion by Reception:-

Type of Registration	*HSCR1/HS200/Medical Card*			
Photographic ID copied	*Yes*	*Date:* ________	*(initial)*	________
Proof of Residency copied	*Yes*	*Date:* ________	*(initial)*	________
Visa/Permit copied (if necessary)	*Yes*	*Date:* ________	*(initial)*	________
Ethnic Origin coded	*Yes*	*Date:* ________	*(initial)*	________
Smoking Status/Alcohol Status Coded	*Yes*	*Date:* ________	*(initial)*	________
Smoking cessation advice given (if necessary)	*Yes*	*Date:* ________	*(initial)*	________