



Date of Registration: _____
EMIS Number: _____ Your Initials: _____

## The Castle Practice

**UNDER 18**

### 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:								
ADDRESS	PREVIOUS ADDRESS								
HAVE YOU LIVED OUTSIDE OF THE UK FOR ANY PERIOD OF TIME IN THE LAST 10 YEARS? <span style="float: right;">YES/NO</span> <span style="float: right;">(Reception - if Yes - Form HS22X needed)</span>									
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:								
School/College Attending: Name and Address	Please list details of any person/persons living at the registered home address, who IS NOT registered with the Castle Practice <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;">Name</th> <th style="width: 15%;">DOB/Age</th> <th style="width: 35%;">Relationship to Child</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	Name	DOB/Age	Relationship to Child					
Name	DOB/Age	Relationship to Child							
<b>ETHNIC ORIGIN - Please circle accordingly</b>									
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;"><b>White</b> British Irish Other</td> <td style="width: 25%;"><b>Asian or Asian British</b> Indian Pakistani Bangladeshi Other</td> <td style="width: 25%;"><b>Mixed</b> White and Black Caribbean White and Black African White and Asian Other</td> <td style="width: 25%;"><b>Black or Black British</b> Caribbean African Other</td> </tr> </table>	<b>White</b> British Irish Other	<b>Asian or Asian British</b> Indian Pakistani Bangladeshi Other	<b>Mixed</b> White and Black Caribbean White and Black African White and Asian Other	<b>Black or Black British</b> Caribbean African Other	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 100%;"><b>Chinese or other Ethinc group</b> Chinese Other</td> <td><b>Not Stated or Other</b></td> </tr> <tr> <td> </td> <td> </td> </tr> </table>	<b>Chinese or other Ethinc group</b> Chinese Other	<b>Not Stated or Other</b>		
<b>White</b> British Irish Other	<b>Asian or Asian British</b> Indian Pakistani Bangladeshi Other	<b>Mixed</b> White and Black Caribbean White and Black African White and Asian Other	<b>Black or Black British</b> Caribbean African Other						
<b>Chinese or other Ethinc group</b> Chinese Other	<b>Not Stated or Other</b>								

#### SECTION B - HEALTH STATUS INFORMATION

<b>SMOKING STATUS - Have you ever smoked?</b> <span style="float: right;">Yes/No</span> If Yes, are you a current smoker? <span style="float: right;">Yes/No</span> If Yes, how many do you smoke per day? _____ If Yes, please see additional handout given by receptionist.
--

**SECTION C - MEDICAL HISTORY**

Do you suffer from -	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

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

\_\_\_\_\_

\_\_\_\_\_

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

**VACCINATION HISTORY**

*Please provide a copy of your childs vaccination history. This can either be a printout from your previous GP surgery or a copy of your childs Red Book information. Without this information we are unable to accept your childs registration.*

**CHECK LIST - FOR COMPLETION BY RECEPTION**

Type of Registration	(circle)	HS22X	HS200	Med Card
HS22X/HS200/Med Card Completed and Signed	Yes	(Initial)	_____	_____
Photographic ID copied	Yes	(Initial)	_____	_____
Visa copied	Yes	(Initial)	_____	_____
Ethnic Origin coded (9S)	Yes	(Initial)	_____	_____
Smoking Status/Alcohol Status Coded	Yes	(Initial)	_____	_____
Vaccination History Copied	Yes	(Initial)	_____	_____