

# LEICESTER TERRACE HEALTH CARE CENTRE NEW PATIENT REGISTRATION FORM

IT IS IMPORTANT THAT YOU COMPLETE ALL SECTIONS (Please write clearly)

Surname: \_\_\_\_\_ Forename: \_\_\_\_\_

DOB: \_\_\_\_\_ Male / Female (Circle)

Address: \_\_\_\_\_ Post Code \_\_\_\_\_

Tel: Home \_\_\_\_\_ Mobile No \_\_\_\_\_ E-mail \_\_\_\_\_

May we send you text reminders on your phone? Home: YES / NO & Mobile: YES / NO

1. Height: \_\_\_\_\_ cms or; \_\_\_\_\_ ft / inches

2. Have you ever smoked? YES / NO

3. If YES, but ex-smoker, when did you give up? Year: \_\_\_\_\_

4. Do you smoke at present? YES / NO

5. If NO, go to Question 9.

6. If YES, how many per day: Cigarettes \_\_\_\_ / Cigarettes (roll own) \_\_\_\_ / Cigar \_\_\_\_ / Pipe \_\_\_\_

7. Would you like to give up smoking? YES / NO

8. Would you like help & assistance in stop smoking? YES / NO

9. Do you have any allergies? YES / NO

10. If so, please specify your allergies \_\_\_\_\_

11. Are you a Carer (caring for someone in a non-professional capacity)? YES / NO

12. Do you currently have a Carer? YES / NO

13. Have you ever been involved with a Children's Social Service Team? YES / NO

14. Please use the blood pressure and weight recording machine in reception area.

Record your answers here:

Weight \_\_\_\_\_ Blood pressure \_\_\_\_\_

15. If you take regular medications (repeats) please list below, with dosage and make an appointment with a Doctor when your registration is complete to discuss your current medication requirements.

16. Nationality: \_\_\_\_\_ Main spoken Language: \_\_\_\_\_

17. Ethnic Group (please circle): British or Mixed British / English / Irish / Polish / White & Black African /

Chinese / White & Asian / White & Black Caribbean / Indian or British Indian / African / Caribbean

Pakistani or British Pakistani / Bangladeshi or British Bangladeshi

Other Black, Asian, White or mixed background (please state) .....

18. Please state any serious illnesses/operations/accidents/disabilities

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19. Please state any family history of serious illness or inherited disease

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20. Do you have an existing **Summary Care Record**? YES / NO

Do you wish to opt out? YES / NO

Would you like more time to make your decision? YES / NO

## AUDIT-C QUESTIONNAIRE

Patient Name ..... Date of Visit .....

1. How often do you have a drink containing alcohol?

- a. Never
- b. Monthly or less
- c. 2-4 times a month
- d. 2-3 times a week
- e. 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?

- a. 1 or 2
- b. 3 or 4
- c. 5 or 6
- d. 7 to 9
- e. 10 or more

3. How often do you have six or more drinks on one occasion?

- a. Never
- b. Less than monthly
- c. Monthly
- d. Weekly
- e. Daily or almost daily