New patient registration form – Redwell Medical Centre **ADULT**

1 Turner Rd, Wellingborough, Northants NN8 4UT. 01933 423424 www.redwellmedicalcentre.co.uk.
Please complete one per each adult member of the family. All responses are strictly confidential.

Full name		**Tel. home**	
Date of birth		**Mobile**	
Next of kin, name and relationship. Contact no.		**Work**	
		Email	
I give explicit consent for the Practice to contact me using any of the above contact details which may include text messaging.			Yes/No

Are **you a carer** for anyone?	Yes / No	If yes, details…
Do you **have a carer**?	Yes / No	If yes, details…
If you are happy for your named carer to discuss and have access to your medical records, please sign here:		

Please see our website for links to Northants Carers for more information.

Height (feet/inches or cm)		**Weight** (stones or Kg)	
Do you smoke?	Yes / ex-smoker / never smoked (please circle which is relevant)		
If yes, how many per day?			
Please ask reception for information if you wish help to quit smoking. If you smoke and do not wish help please declare below…			
I smoke and am aware that this is bad for my health. Signed:			

Alcohol consumption:-
Please complete the enclosed questionnaire. If you want support or advice on alcohol, contact **0300 126 5700** or look at Stop smoking | North Northamptonshire Council (northnorthants.gov.uk)

Your religion (circle one)	None Church of England Catholic Buddhist Hindu Jewish Jehovah's witness Muslim Sikh Other (please specify)…..
Ethnic origin (circle one)	White (UK) White (Irish) White (other) Asian Indian/Brit. Indian Chinese Pakistani/Brit. Pakistani Bangladeshi/Brit. Bangladeshi Other Asian African Caribbean Other Black Mixed Other (please specify)…..
First language (circle one)	English Bengali Gujarati Hindi Italian Punjabi Polish Romanian Ukranian Urdu Other (please specify) …..
Interpreter?	Will you require an interpreter for your appointments? **Yes / No**

Family History (please circle yes/no/not known and provide more information – continue overleaf if need)

		Who (parent, siblings, child etc)?, **What Age**?
Heart attack or angina	Yes/No/NK	
Stroke	Yes/No/NK	
Diabetes	Yes/No/NK	
Asthma	Yes/No/NK	
High blood pressure	Yes/No/NK	
Cancer (specify type)	Yes/No/NK	
Thalassaemia	Yes/No/NK	
Sickle Cell Disease	Yes/No/NK	
Other significant illness	Yes/No/NK	

Disability or Special needs? Do you have a social worker?

Please let us know if you have any disability or special needs (circle any below and provide details in space available)
Learning difficulty Visual loss Hearing Loss Assistance Dog Speech problems Mobility problems Mental Health Other Social worker (please provide details)

Your medicines and allergies

Allergies (if none, state "none")	
Do you have **difficulty with taking medications?** Please circle	None Swallowing difficulty Opening containers Remembering medication Other (please specify) ….
We will require a copy of your recent medications list from your previous pharmacist or GP surgery before we can issue the medication. You will need to see a Clinician before the medication is put on repeat. All prescriptions are now sent electronically directly to a pharmacy of your choice – please tell us what pharmacy you would like to use as your main pharmacy:	

Your medical problems (current and important past problems)

Please let us know your medical problems as it sometime takes many weeks before we receive your medical records. In particular let us know of any heart disease, stroke, diabetes, cancers, epilepsy or any other condition causing you significant disability or requiring ongoing medication.

Military service personnel

Your service no: Enlistment date:	Any condition that entitles you to NHS priority treatment? **Yes / No** (explain more in box below)

Firefighter: yes/no (circle)
If you are/were a Firefighter, a relevant code regarding occupational exposure to toxins will be added to your record.

Summary Care Record (SCR) This is for sharing information about medication and allergies with other health professionals (e.g. hospitals). I consent to a SCR being created for me **YES / NO** (please circle)

You will find the Practice Privacy Notice displayed in the waiting area and also on our website.

Please check that you have completed <u>all sections</u> of this form correctly. *<u>If you do not complete this form correctly your registration will not be accepted.</u>* Thank you for your help.

For more information about the services we offer, please pick up a patient information leaflet or see our website www.redwellmedicalcentre.co.uk

For office use only – please check all fields are completed.	Checked by…	Date