

FOR OFFICE USE ONLY	
Proof of identification	PASSPORT <input type="checkbox"/> DRIVING LICENCE <input type="checkbox"/> OTHER(please state):
Proof of address	BANK STATEMENT <input type="checkbox"/> UTILITY BILL <input type="checkbox"/> OTHER(please state):
Checked by:	
Date registered:	

Contact and Demographic Details	
Title: Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/>	Surname:
DOB:	Firstname(s):
NHS no (if known):	Previous surname:
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	Town & country of birth:
Home address:	
Home tel no:	Work tel no:
<i>To help trace your medical records please fill out the following information as applicable</i>	
Email address:	Mobile no:
By supplying your email address you consent to the practice contacting with information, invites, results etc.	By supplying your mobile number you consent to the practice contacting you with information, reminders etc via text message.
Ethnicity: WHITE <input type="checkbox"/> BLACK AFRICAN <input type="checkbox"/> BLACK CARIBBEAN <input type="checkbox"/> INDIAN <input type="checkbox"/> PAKISTANI <input type="checkbox"/> CHINESE <input type="checkbox"/> DECLINE TO STATE <input type="checkbox"/> OTHER(please state) <input type="checkbox"/>	
Main spoken language:	
Previous address in the UK:	
Previous GP Practice while at previous address given above:	
Are you a current member of the armed forces?	Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>Please note that written authorisation from the DMS must accompany this form if you are a current member of the armed forces.</i>	
<i>Patients from abroad</i>	
If you are from abroad, your first UK address where you were registered with a GP:	
If previous a UK resident, date you left UK:	
Date you first came to the UK:	
<i>Patients returning from the Armed Forces</i>	
Address before enlisting:	
Enlistment date:	
Date of discharge:	

Family History			
	Relation		Relation
Coronary Heart Disease <input type="checkbox"/>		Stroke <input type="checkbox"/>	
Diabetes <input type="checkbox"/>		High blood pressure <input type="checkbox"/>	
Epilepsy <input type="checkbox"/>		Asthma <input type="checkbox"/>	
Hypothyroidism <input type="checkbox"/>		Cancer <input type="checkbox"/>	
Chronic Obstructive Pulmonary Disease <input type="checkbox"/>		Serious mental illness <input type="checkbox"/>	

About You		
Height:	Weight:	
Known allergies:		
Are you an unpaid carer for someone?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do you have a friend/relative who is your carer?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Please provide their name and address if applicable.		
If you are on any regular medication please attach a copy of your medication repeat ordering slip from your previous surgery.		
Next of Kin Details		
Name	Relationship	Contact tel. no

About Your Lifestyle											
Do you smoke?	Yes <input type="checkbox"/> No <input type="checkbox"/>										
If yes do you smoke (please tick)	CIGARETTES <input type="checkbox"/> CIGARS <input type="checkbox"/> PIPE <input type="checkbox"/>										
How many cigarettes/cigars do you smoke a day?	<table border="1" style="width: 100%; text-align: center;"> <tr> <td><1</td> <td>1-9</td> <td>10-19</td> <td>20-39</td> <td>40+</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	<1	1-9	10-19	20-39	40+	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<1	1-9	10-19	20-39	40+							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
If you smoke a pipe, how many ounces per week?											
Are you an ex-smoker	Yes <input type="checkbox"/> No <input type="checkbox"/>										
How many did you smoke?											
When did you give up?											

Communication Needs			
We're improving how we communicate with patients. Please indicate below if you require information in a different format or need communication support.			
I am deaf/hard of hearing	<input type="checkbox"/>	I am blind/visually impaired	<input type="checkbox"/>
I use a BSL interpreter	<input type="checkbox"/>	I need information in large print format	<input type="checkbox"/>
I use a communication advocate	<input type="checkbox"/>	I need information in easy read format	<input type="checkbox"/>
I lip read	<input type="checkbox"/>	I need information in Braille	<input type="checkbox"/>
Other communication needs (please specify):			

Data sharing consent

Please read the accompanying leaflet which details what part of your record is extracted and how it is used to help other NHS organisations/providers. The data sharing programmes are designed to improve both the individual care you receive, and to understand the needs of patients as a whole in your area. The data extracted is secure and only accessible to authorised staff.

To opt **OUT** of any of the following data sharing programmes please tick the appropriate box.

Data for research

I do not wish identifiable data about me to leave the practice.

I do not wish data about me to be shared by HSCIC.

Summary Care Record

I do not wish to have a Summary Care Record.

(Please note this will mean NHS healthcare staff may not be aware of your current medications, any allergies or adverse reactions to previous medication)

Hampshire Health Record

I do not wish to have a Hampshire Health Record.

Signature:

Date: