Peel Group Practice
Registration Form & Health Questionnaire
(please complete as fully as possible)

Albany Road, Peel, Isle of Man, IM5 1HU Telephone Number – 01624 686968 www.peeldoctors-iom.com

These questions are to help your new General Practitioner to get to know you and your medical problems. All questions will be handled confidentially by the Practice team. Please complete the questions and estimate dates if you are not sure (please say if it is approximate). When you receive your medical card, it will show you as registered with a particular doctor. **You are registered with the Practice and can be seen by any GP.** However, you can ask to be seen by the doctor of your choice, provided, of course, that he or she is available.

Mr /Mrs/ Ms /Miss		**D.O.B**		
Surname		**Gender**	Male	Female
Forename(s)		**Town & Country of Birth**		
Preferred Name		**NHS Number. Not NI Number**		
Previous Surname(s)		**Ethnic Form Completed**	Yes	No
Address		**Main Language Spoken**		
		Home Telephone Number		
		Mobile Number		
Postcode		**Can we contact by text if RQ**	Yes / No	
		Work Number		
Occupation		**Can we contact you at work**	Yes / No	
Email address		**Password Required for Access**		
Next of Kin & Relationship		**Contact Number for Next of Kin**		

Your Previous Address **Name & Address of previous Doctor whilst at that address**

Address		**Name**	
		Address	
Postcode		**Postcode**	

If you are from abroad, your 1st UK address that you registered with a GP

Address		**If previously in UK/IOM, date of leaving**	/ /
		Date you first came to live in UK/IOM	/ /
Postcode			

If you are returning from the Armed Services

Address		**Enlistment Date**	/ /
		Date Of Leaving	/ /
		Service / Personnel No.	
Postcode			

<u>If completing registration form for a child</u> under the age of 16 years, who has Parental Responsibility?

Name		**Relationship**		**Contact Number(s)**	
Name		**Relationship**		**Contact Number(s)**	

Carers

Are you responsible for the care of someone? If so please give their details below				Yes	No
Or Does someone "care" for you? (If so please give details below)				Yes	No
Name		**Relationship**		**Contact Number(s)**	
Address					

Ethnicity

Which **ethnic group** do you belong to? (please tick one box ONLY)

- ☐ White
- ☐ White British
- ☐ White Irish
- ☐ White European
- ☐ White other (please specify) ……..
- ☐ Black or Black British
- ☐ Black Caribbean
- ☐ Black African
- ☐ Black other (please specify) …….
- ☐ Asian or Asian British
- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Asian other (please specify) ……..
- ☐ Chinese
- ☐ Greek
- ☐ Turkish
- ☐ Other Ethnic Group (please specify) ……

What is your **first language**? (ie. Learnt at school) ……..

Do you speak English? …….. Do you need an interpreter? …….

General Health History

Have you had any serious illness or recent operations, please give details and dates?

Have you ever suffered from:

Blood Pressure problems	Yes/No	Epilepsy	Yes/No	
Angina	Yes/No	Asthma	Yes/No	
Heart Attacks	Yes/No	Cancer	Yes/No	
Strokes	Yes/No	Mental Health issues	Yes/No	
COPD/Chronic Bronchitis	Yes/No	Diabetes	Yes/No	Type1/Type2

Under active Thyroid Gland Yes/No

Other illness/condition you consider relevant ……

Do you consider yourself to have a physical disability? Yes/No If yes, it would be helpful to have brief details):
……

Do you consider yourself to have a learning disability? Yes/No (If yes, it would be helpful to have brief details):
……

Do you have any family history of any of the following illnesses? (Please tick box if YES)

Diabetes ☐ Heart Disease ☐ Blood Pressure ☐ Stroke ☐ Asthma ☐ Osteoporosis ☐

Other illness you consider relevant ……

Have you had any operations? What and When?

……

……..

Immunisations if known

Diphtheria		Polio	
German Measles		Tetanus	
Typhoid		Measles	
Cholera		BCG	
Yellow Fever		MMR	
Whooping cough		Hepatitis A	
Other		Other	

Women only:

Have you ever had an abnormal smear? Yes/No When?……..

Date and result of your last smear test ……..

Are you pregnant at the moment? YES/NO

If yes, what is your estimated date of delivery?…… How many previous children? ……..

What contraception is currently used? ……

Please give details of any medication which you take (prescribed or otherwise): please attach a copy of your "repeat" slip if possible

Name of drug: …… Name of drug: ……
Dosage: …… Dosage: …….

Name of drug: …… Name of drug: ……
Dosage: …… Dosage: …….

Name of drug: …… Name of drug: ……
Dosage: …… Dosage: ……

Have you any allergies to medicines, or anything else?

Do you have any issues or problems that you would like to discuss with the Doctor or Nurse? Yes/No

New Patient Medical Required for ALL Patients

Date…… Time……

We have a sharing agreement with the Manx Emergency Doctors, if you contact them outside surgery hours you will be asked for consent at the start of the consultation. If you give consent this means that the Doctor will be able to view all your details the practice holds. They will update your record and the Practice will be able to view this.

Do you currently smoke? Yes/No

☐ Never smoked

☐ Ex-smoker: When stopped …… How many did you smoke per day? ……

☐ Smoker: Amount per day: …….. cigarettes …….. pipe …… cigars

☐ How many years have you smoked? ……..

Would you like to stop smoking ? Yes/No

Would you like an appointment to see a Nurse for advice and/or support? Yes/No

Do you take/use any recreational drugs? Yes/No What and how often…… ……

Do you see DAT? Yes/No

Do you have any concerns about your weight? Yes/No

What is your height? ……..

What is your weight? ……..

Do you Exercise?? Please complete

1. Please tell us the type and amount of physical activity involved in your work. Please tick one box that is closest to your present work from the following five possibilities:

		Please mark one box only
a	I am not in employment (e.g. retired, retired for health reasons, unemployed, full-time carer etc.) *Please answer whether you are in employment or not*	
b	I spend most of my time at work sitting (such as in an office)	
c	I spend most of my time at work standing or walking. However, my work does not require much intense physical effort (e.g. shop assistant, hairdresser, security guard, childminder, etc.)	
d	My work involves definite physical effort including handling of heavy objects and use of tools (e.g. plumber, electrician, carpenter, cleaner, hospital nurse, gardener, postal delivery workers etc.)	
e	My work involves vigorous physical activity including handling of very heavy objects (e.g. scaffolder, construction worker, refuse collector, etc.)	

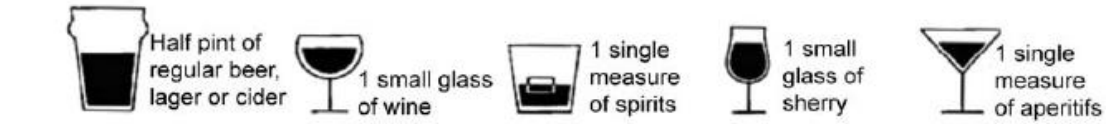
2. During the ***last week***, how many hours did you spend on each of the following activities?

	Please mark one box only on each row	None	Some but less than 1 hour	1 hour but less than 3 hours	3 hours or more
a	Physical exercise such as swimming, jogging, aerobics, football, tennis, gym workout etc.				
b	Cycling, including cycling to work and during leisure time				
c	Walking, including walking to work, shopping, for pleasure etc.				
d	Housework/Childcare				
e	Gardening/DIY				

3. How would you describe your usual walking pace? Please mark one box only.

Slow Pace (i.e. less than 3 mph)	☐	Steady Average pace	☐	Brisk Pace	☐	Fast pace (i.e. over 4mph)	☐

This is one unit of alcohol…



...and each of these is more than one unit

FAST	Scoring system					Your score
	0	1	2	3	4	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only answer the following questions if the answer above is Never (0), Less than monthly (1) or Monthly (2). Stop here if the answer is Weekly (3) or Daily (4).						
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring:
If score is 0, 1 or 2 on the first question continue with the next three questions

If score is 3 or 4 on the first question – stop here.
An overall total score of 3 or more is FAST positive.

SCORE

What to do next?

If FAST positive, complete remaining AUDIT questions (this may include the three remaining questions above as well as the six questions on the second page) to obtain a full AUDIT score.

Score from FAST (other side)

SCORE

Patient Name: ……..…….. DOB: ……

Remaining AUDIT questions

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 8	10+	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	

TOTAL AUDIT Score (all 10 questions completed):
0 – 7 Lower risk,
8 – 15 Increasing risk,
16 – 19 Higher risk,
20+ Possible dependence

Declaration: I declare that to the best of my knowledge the information contained in this form is true and accurate. I understand that personal details about me will be held in both electronic and paper form at Peel Group Practice in connection with my healthcare, and that all such information will be held in compliance with the requirements of the Data Protection Act 2002.

Signed: ..... **Date: .....**

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Office Use only – Form to be completed fully before patient can be registered

Received: date: ..... initials: .....

Photo ID: passport/driving licence/bus pass/student ID card/Other (specify) .....
Valid until: ..... Name same as application: YES/NO

Alcohol questions score: (score of 5 or above) second questionnaire given/sent date: .....