



Date of Registration:	
EMIS Number:	Your Initials:

The Castle Practice (October 23 version)

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:	
		H&C No:	
ADDRESS		PREVIOUS ADDRESS	
ARE YOU REGISTERING FROM OUTSIDE OF THE UK?		YES/NO	
		(Reception - if Yes - Form HSCR1 needed)	
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:	
ETHNIC ORIGIN - Please circle accordingly			
White British Irish Other	Asian or Asian British Indian Pakistani Bangladeshi Other	Mixed White and Black Caribbean White and Black African White and Asian Other	Black or Black British Caribbean African Other
Chinese or other Ethinc group Chinese Other		Not Stated or Other 	

SECTION B - HEALTH STATUS INFORMATION

SMOKING STATUS - Have you ever smoked? If Yes, are you a current smoker? How many do you smoke daily?	Yes/No Yes/No _____
ALCOHOL STATUS - Do you drink alcohol?	
Yes/No If Yes, how many units would you drink per week?	

New Patient Registration Questionnaire

Page 2

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 provide a list of your medication from your previous GP surgery

Castle Practice participates in the Department of Health led Benzodiazepines Reduction and Opioids Reduction programme.
Patients should be aware that prescriptions and medications will be reviewed in line with the Department of Health Guidelines.

PLEASE TICK HERE TO CONFIRM YOU HAVE READ THIS NOTICE ☐

ZERO TOLERANCE - In line with the Department of Health, Social Services and Public Safety Circular HSS (Gen) (3) 2007 - "Zero Tolerance on Abuse of Staff, Protecting Healthcare and Emergency Staff from Violence", the Castle Practice is committed to the creation of a culture and environment where employees may undertake their duties without fear of abuse or violence.

Non-Physical Abuse; The use of inappropriate words or behaviour causing distress and/or constituting harassment. This includes receipt of abusive telephone calls from any source
Physical Abuse; The intentional application of force against the person or another without lawful justification resulting in physical injury or personal discomfort.

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

VACCINATIONS - Please list any known vaccinations received in the last 10 years

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

For completion by Reception:-

Type of Registration	HSCR1/HS200/Medical Card			
Photographic ID copied	Yes	Date:	_____	(initial) _____
Proof of Residency copied	Yes	Date:	_____	(initial) _____
Visa/Permit copied (if necessary)	Yes	Date:	_____	(initial) _____
Ethnic Origin coded	Yes	Date:	_____	(initial) _____
Smoking Status/Alcohol Status Coded	Yes	Date:	_____	(initial) _____
Smoking cessation advice given (if necessary)	Yes	Date:	_____	(initial) _____