Providing NHS services

DR R KOTNIS
DR I BRATBY
DR B HERNANDEZ-DIAZ

ST CLEMENTS SURGERY
39 TEMPLE STREET
OXFORD
OX4 1JS

Tel: 01865 248550
Email: stclements.reception@nhs.net
Website: https://www.stclementssurgery.org

IDENTIFICATION DOCUMENTS REQUIRED WHEN REGISTERING AS A NEW PATIENT

When returning the completed registration form, please bring your proof of identification. We are unable to register you without this.

PHOTO ID

Driving Licence (Valid)
Passport (Valid)
Student/Work ID

PROOF OF ADDRESS:
MUST BE DATED WITHIN THE LAST 3 MONTHS

Utility Bill
Council Rent Book
Bank Statement
Credit Card Statement
Letter from Benefits Agency

Please note if applying for Online Access to your medical records, photo ID must be produced

Information for our patients.

We're improving how we communicate with patients.
Please tell us if you need information in a different format or need communication support.

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NEW PATIENT HEALTH QUESTIONAIRE

Contact information

Title:	
Forename:	
Surname:	
Date of birth:	
Marital status:	
Landline number:	
Mobile number:	
Email address:	
Home address:	
Next of kin details	**Name:** **Relationship:** **Contact number:** **Address:**

Please circle your ethnic group:

White	British	Irish	Other	
Black	Caribbean	African	Other	
Asian	Indian	Pakistani	Chinese	Other

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Are you a registered carer? **YES/NO**

If so, we would like to support you and ask that you please complete the following:

Contact details

Name:

Relationship:

Contact number:

Address:

Do you have a carer? If yes, please provide contact details: **YES/NO**

Contact details

Name:

Relationship:

Contact number:

Address:

Do you have a physical or mental impairment, learning disability or any other disability? **YES/NO**

Please provide details:

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Additional Information

Height:

Weight:

What is your first language?

As a practice, we offer new patient appointment's, would you like to book one? **YES/NO**

Do you have any allergies? Please list below: **YES/NO**

Are you taking any regular medication? Please list below: **YES/NO**

Lifestyle Information

Do you exercise regularly? **YES/NO**

Do you keep to a special diet? **YES/NO**

Has your cholesterol level been checked in the last 2 years? **YES/NO**

Have you ever or are you currently suffering from any of the following? Please circle below.

High Blood Pressure	Asthma	Epilepsy
Heart Disease	Chronic Lung Disease	Migraine
Atrial Fibrillation	Depression/Anxiety	Osteoporosis
Stroke/TIA	Eating Disorder	Coeliac Disease
Arterial Disease	Dementia	Arthritis
Diabetes	Other Mental Health Problems	Chronic Kidney Disease
Cancer	Thyroid Disease	HIV
Learning Disability	Registered Disabled	Blindness/Glaucoma

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Smoking

Please circle and provide details below for the following:

Do you smoke?	**YES/NO**
If yes, how many?	Trivial Smoker: <1 cigarettes per day Light Smoker: 1-9 cigarettes per day Moderate Smoker: 10-19 cigarettes per day Heavy Smoker: 20-39 cigarettes per day
If yes, please see information for smoking cessation advice.	Smoke Free Life Oxfordshire now offer Smoking Cessation Advice – Contact details for them are 01865 238936 or 080024610712
If you are an ex-smoker, what date did you quit?	

Alcohol Consumption

Please circle below the option which applies best, using the image for reference:

Do you drink?	**YES/NO**
If yes, how much?	Trivial drinker: <1 unit per day Light drinker: 1-2 units per day Moderate drinker: 3-6 units per day Heavy drinker: 7-9 units per day
Have you never consumed alcohol?	**YES/NO**
Have you stopped drinking alcohol? If yes, when?	**YES/NO**

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Family History

Please give details of any illnesses which run in your family or affect your immediate family (parents, brothers, sisters, grandparents or your children).

Glaucoma	Osteoporosis	Obesity
Breast Cancer	Epilepsy	Alzheimer's disease
Other Cancer	Depression	Heart Disorder
Thyroid Disorder	Eczema	CVS disease
Stroke/TIA	Ovarian Carcinoma	Hypertension
Atopy	Dementia	Cataract
Migraine	Tuberculosis	Other, (if so, please specify)
Diabetes Mellitus (Type 1 or Type 2)	Mental Disorder	

For women only:

Have you ever had a cervical cytology test before? **YES/NO**

If yes, please tell us the date of your last smear test:

Was the result normal? **YES/NO**

What method of birth control/contraception do you use?

How many pregnancies have you had?

What happened in each pregnancy? (E.g. caesarean, miscarriage, termination). Please include dates:

Have you ever had a hysterectomy (womb removed)? **YES/NO**

If yes, please tell us the date:

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Assistance During Appointments

In order for us to provide you with any assistance you may require, please let us know if you would benefit from any of the following:

If your first language is NOT English – do you require a translator?	**YES/NO**
If you are deaf – do you require a sign language translator?	**YES/NO**
If you have a disability – do you require any additional support, such as wheelchair access or an induction loop?	**YES/NO**