



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

Castletown Road, Port Erin, Isle of Man, IM9 6BD

Telephone Number – 01624 686979

www.southerngrp.co.uk

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). **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.

<b>Have you ever been registered in UK, could you have an NHS number?</b>	Yes / No
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<b>Mr /Mrs/ Ms /Miss</b>		<b>D.O.B</b>	
<b>Surname</b>		<b>Gender</b>	Male      Female
<b>Forename(s)</b>		<b>Town &amp; Country of Birth</b>	
<b>Preferred Name</b>		<b>NHS Number. Not NI Number</b>	
<b>Previous Surname(s)</b>		<b>Ethnic Form Completed</b>	Yes      No
<b>Address</b>		<b>Main Language Spoken</b>	
		<b>Home Telephone Number</b>	
		<b>Mobile Number</b>	
		<b>Can we contact by text if RQ</b>	Yes / No
		<b>Work Number</b>	
<b>Postcode</b>		<b>Can we contact you at work</b>	Yes / No
<b>Occupation</b>		<b>Password Required for Access</b>	
<b>Email address</b>		<b>Contact Number for Next of Kin</b>	
<b>Next of Kin &amp; Relationship</b>			

**Your Previous Address**

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

<b>Address</b>		<b>Name</b>	
		<b>Address</b>	
<b>Postcode</b>		<b>Postcode</b>	

**If you are from abroad, your 1<sup>st</sup> UK address that you registered with a GP**

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

**If you are returning from the Armed Services**

<b>Address</b>		<b>Enlistment Date</b>	/ /
		<b>Date Of Leaving</b>	/ /
<b>Postcode</b>		<b>Service / Personnel No.</b>	

**If completing registration form for a child under the age of 16 years, who has Parental Responsibility?**

<b>Name</b>		<b>Relationship</b>		<b>Contact Number(s)</b>	
<b>Name</b>		<b>Relationship</b>		<b>Contact Number(s)</b>	

**For children 12 and under we need consent to advise the Community Health Visitor that they have joined the practice.** To share this information we need parental/guardian consent. The patient's name, age, demographics, contact details and name parent / guardian.

Yes	No
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**Patient Online Access – book appointments, see blood results etc online**

Patient Online Access Form completed? Only for 16 years ++	Yes / No
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**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			
For staff use only: to be coded on EMIS		224484003	Is a Carer

**Ethnicity**

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

<input type="checkbox"/> White	<input type="checkbox"/> Asian or Asian British
<input type="checkbox"/> White British	<input type="checkbox"/> Indian
<input type="checkbox"/> White Irish	<input type="checkbox"/> Pakistani
<input type="checkbox"/> White European	<input type="checkbox"/> Bangladeshi
<input type="checkbox"/> White other (please specify) .....	<input type="checkbox"/> Asian other (please specify) .....
<input type="checkbox"/> Black or Black British	<input type="checkbox"/> Chinese
<input type="checkbox"/> Black Caribbean	<input type="checkbox"/> Greek
<input type="checkbox"/> Black African	<input type="checkbox"/> Turkish
<input type="checkbox"/> Black other (please specify) .....	<input type="checkbox"/> 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?

<b>Have you ever suffered from:</b>			
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		
<b>Other illness/condition you consider relevant</b> .....			

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

<b>Do you have any family history of any of the following illnesses?</b> (Please tick box if YES)						
Diabetes <input type="checkbox"/>	Heart Disease <input type="checkbox"/>	Blood Pressure <input type="checkbox"/>	Stroke <input type="checkbox"/>	Asthma <input type="checkbox"/>	Osteoporosis <input type="checkbox"/>	
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?**

**Would you like a pre-registration appointment with the Practice Nurse to discuss any issues or problems?**

Yes/No

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.**

**Consent** Yes/No

**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.) <i>Please answer whether you are in employment or not</i>	
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.)	

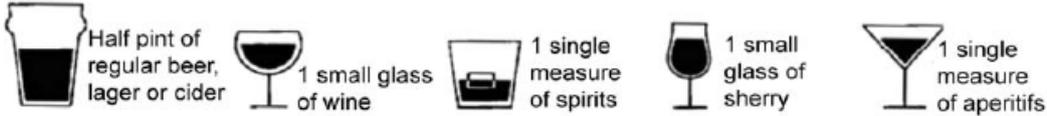
2. During the **last week**, how many hours did you spend on each of the following activities?

	<i>Please mark one box only on each row</i>	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) <input type="checkbox"/>	Steady Average pace <input type="checkbox"/>	Brisk Pace <input type="checkbox"/>	Fast pace (i.e. over 4mph) <input type="checkbox"/>
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# 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	
<b>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).</b>						
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.**

### 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)

Patient Name: ..... DOB: .....

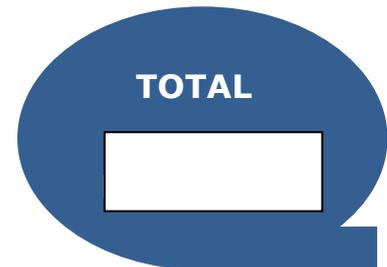


## Remaining AUDIT questions

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 Southern Group Practice in connection with my healthcare, and that all such information will be held in compliance with the requirements of the GDPR and LED Implementing Regulations 2018. Please note form needs to be completed returned to surgery with ID.

**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: .....  
 Consent to share information with Health visitor for children 12 and under: YES/NO

<b>Patient Online Access Form completed?</b>		<b>Linkage Letter Printed</b>	
<b>Only for patients 16 years +++</b>	Yes / No		Yes / No