Padiham Medical Centre
36 Burnley Road
Padiham, BB12 8BP
Doctors Savage, Fleming, Appleyard, Narayana and Zawar

New Patient Registration – Application Form

Patient Details

Full Name, including Title (eg Mr / Mrs):	
Previous Surname:	
Date of Birth:	
Occupation:	
Full Postal address:	
Home & Mobile Telephone Numbers:	
E Mail Address:	
Name & Address of previous GP:	
Next of Kin:	
What is your Ethnic Group?	
What is your main language?	
Do you have a carer?	
Are you a carer?	
Are you registered disabled?	
Do you hold a living will?	

Medical Information

Have you ever suffered from any of the following:

Epilepsy	Yes	No
High Blood Pressure	Yes	No
Heart Attack/Stroke	Yes	No

Cancer	Yes	No
Eczema/Hay Fever	Yes	No
Blindness/Glaucoma	Yes	No
Diabetes	Yes	No
Depression	Yes	No
Asthma	Yes	No

Please list any serious illnesses/operations/disabilities (and for women any pregnancy related problems and the year they took place:-
Are you allergic to any medicines and if so which? Yes/No Please list any medicines being taken and the amount: Any medication requested will need to be evidenced with your repeat list from your last surgery or you medication boxes/ labelled at your registration appt with the nurse
Have you ever refused treatment/screening of any kind and if so what?

Other Information

Do you smoke? Yes/No If No – Have you ever smoked? Yes/No If yes how many cigarettes or ounces of tobacco per week? Would you like advice on giving up smoking? Yes/No
What is your Height?
What is your Weight?
Family History - please state any serious illness, in particular heart disease, stroke, high blood pressure, diabetes or any inherited disease

For Patients aged 65 and over or those with a chronic disease (e.g. asthma or diabetes)

Have you had a flu vaccination? If yes please enter the date	
Have you had a pneumococcal vaccination? If yes please enter the date	

Internet Booking for GP Appointments

The Practice now offers appointment booking via its web site through a facility called 'Patient Access'. If you wish to register to have the choice to make appointments with a doctor via the internet please tick this box and your personal registration details will be sent to you in the post.	

Text Reminder Service

The Practice will automatically send you a text reminder for your appointments and for health promotions. If you DO NOT wish to receive reminders please tick this box.	

Alcohol Screening Questionnaire

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 have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last 6 months?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

If you score 5 or more than please continue on to the next set of questions

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often during the last 6 months had you found that you were not able to stop drinking once you had started	Never	Less than monthly	Monthly	Weekly	Daily	
How often in the past 6 months have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily	
How often during the past 6 months 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	
How often during the last 6 months have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

How often during the last 6 months 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	
Have you or somebody else been injured as a result of your drinking?	No				Yes	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No				Yes	

Total Score of questions 1-10 =

Signature of patient applying for registration:	
Date of application:	

- ***Submitting this form will NOT automatically register you with the surgery.***
- ***Submitting this form does NOT guarantee or even imply that you will be accepted onto the practice register.***
- ***You will be asked to provide satisfactory identification showing your permanent registered address.***
- ***You will be asked to attend a new patient medical as part of the registration process***

The following section is for Practice use only

Member of staff to confirm identification seen (please tick relevant box):

Birth Certificate ☐	**Driving Licence** ☐	**Passport** ☐
Allowance Book ☐	**Rent Book** ☐	**Utility Bill** ☐
Other (please specify):		

Identification Seen By: (Name of member of staff)	
Date identification seen:	