

WELCOME TO ISLINGTON CENTRAL MEDICAL CENTRE

Thank you for joining Islington Central Medical Centre.

To ensure that we have up to date medical and personal details please complete this registration questionnaire. The information you give is confidential. **PLEASE PRINT CLEARLY.** If you have problems completing any section please ask for assistance.

Title (Mr/Mrs/Ms/Miss/Other)	Male/Female
Surname	Forename
Previous Names (if any)	
Date of Birth	Marital Status
Address	
Home Tel	Mobile Tel
Email Address	
Occupation	
First language:	
Interpreter required	Yes / No
<u>Person to be contacted in case of an emergency</u>	
Name	Contact Number
Relation to you	

MEDICAL DETAILS

Medical History (past and present) e.g. diseases, operations with dates if known
Current medication
Drug Allergies

FAMILY HISTORY	YES/NO	Relation to you
Stroke		
Heart Disease under 60		
Heart Disease over 60		
Diabetes under 60		
Asthma		
Cancer		

LIFESTYLE

Blood Pressure	(THIS WILL BE CHECKED BY STAFF)	
Height	Weight	
Do you smoke? Yes	Cigarettes per day	Tobacco per day
Never smoked		
Ex smoker	Cigarettes per day:	Date stopped:

1. How often do you have a drink containing alcohol?					Your Score
Never Score 0	Monthly Score 1	2-4 times a month Score 2	2-3 times a week Score 3	4 or more times a week Score 4	
2. How many standard drinks (units)* containing alcohol do you have on a typical day when you are drinking?					
1-2 Score 0	3 or 4 Score 1	5 or 6 Score 2	7 or 8 Score 3	10 or more Score 4	
3. How often do you have 6 or more standard drinks* on one occasion?					
Never Score 0	Less than monthly Score 1	Monthly Score 2	Weekly Score 3	Daily or almost daily Score 4	
4. How many units* of alcohol do you drink on an average week					

*A standard drink (unit) of alcohol (around 10mls or 8g) is contained in:

- A small (125ml) glass of standard strength wine (12%)
- A single (25ml) pub measure of spirits
- Half a pint of normal strength beer or lager

CHLAMYDIA TESTING

If you are a man or a woman between the ages of 16-24 we have free Chlamydia screening programme - a test kit to do yourself. Would you be interested in taking a pack?

YES NO

WOMEN ONLY

Date of last cervical smear:
Result, if known:
Current Contraception:

VACCINATIONS

Parents registering children please provide a copy of immunisations.

CARERS

I have a carer Y / N	I am a carer Y / N
Name of carer:	
Telephone number of carer:	

ISLINGTON CENTRAL MEDICAL CENTRE

Patient Profiling

The practice in line with other healthcare providers and all other statutory services is now collecting information about our patients' ethnicity. This information will help us learn more about the health needs of our local community and allow us to plan services. All the information we receive will be used and treated with the strictest confidence.

If you have any queries about completing this form please ask a member of staff. Otherwise please complete this form below by ticking the ethnic group to which you feel you belong.

Thank you.

Patient Name:

Date of Birth:

White

White
British
Irish
Turkish
Other White

Black

Black or Black British
Caribbean
African
Other Black

Mixed

White / Black Caribbean
White / Black African
White / Asian
Other Mixed

Asian

Asian or Asian British
Indian
Pakistani
Bangladeshi
Other Asian

Chinese or Other Ethnic Group

Chinese
Any other Ethnic Group

For Office Use Only

Two items of proof of residency	()
Form checked and fully completed	()
Ethnicity form completed	()
Date:	Receptionist's Initials: