New Horizons
Medical Partnership
Forest Gate Surgery | Totton Health Centre

New Horizons Medical Partnership
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For Office Use Only	
Identification Seen	Yes ☐ No ☐
Identification description (i.e. Driving Licence, Passport etc.)	
Receptionist Initials	

CONFIDENTIAL MEDICAL REGISTRATION FORM

Please measure your BLOOD PRESSURE on the machine in the waiting room and attach the reading to this form before handing to a receptionist.

Name:	Date of Birth:
First Language	If first language not English would you need an interpreter ☐Yes ☐No

Do you have any special communication needs? ☐Yes ☐No

If Yes: ☐Sign Language ☐Large Print ☐Other……..

Lifestyle

Height:	Weight:	Blood Pressure: /

Lifestyle: Smoking

☐Never smoked ☐Ex-smoker - When did you give up?.....

☐Smoker ……per day Would you like help to quit smoking? ☐Yes ☐No

Lifestyle: Alcohol

1 Drink/unit = ½ pint of beer or 1 standard glass of wine or 1 single measure of spirits

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	☐7-9	☐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 year?	☐Never	☐Less than monthly	☐Monthly	☐Weekly	☐Daily or almost daily

Summary Care Record Scheme

Do you wish to OPT OUT of the Summary Care Record Scheme? Yes ☐ No ☐

****If yes please complete Opt Out form.***

About you

Are you a carer? ☐Yes ☐No

Do you have a carer? ☐Yes ☐No

If yes please tell us the name and address of your carer:…….

…….

Are you happy for us to contact your carer about you? ☐Yes ☐No

Next of Kin details

Name……..... *Telephone Number……*

Address…….……

Relationship to yourself i.e. wife/husband/partner……..……..……..……

Do you wish this person to have access to your medical information? ***Yes*** ☐ ***No*** ☐

If Yes please read and sign the declaration below

I hereby give my consent for the above named person to have access to my personal medical details and be able to use this information in my best interest.

My consent will remain in force unless cancelled by myself in writing.

Patient Signature…….…… *Date……..*

Family History

Have any close relatives (father, mother, sister, brother only) ever suffered from any of the following: (please indicate who in the boxes)

Heart Attack	Stroke	Diabetes	High Blood Pressure	Asthma	Glaucoma	Cancer

Are you a Military Veteran? If Yes, have you handed in your FMED133 Form? **Yes** ☐ **No** ☐

Where you have provided information on how to contact you, can you confirm you are happy for us to contact you by the following:-

By email ☐Yes ☐No Email address…….

By text ☐Yes ☐No Mobile No…….

Leave message on answerphone? ☐Yes ☐No

I confirm that the information I have provided is true to the best of my knowledge

Signature: Date:

☐Signature of patient ☐Signature on behalf of patient