PIONEER MEDICAL GROUP

`Pioneer Medical Group patient registration form
Please complete all questions and return to reception

Title	First Name	Surname
Date Of Birth		Email Address
Home telephone		Mobile number
Address		Postcode
Pharmacy name:		(to be used for electronic prescriptions)
Location:		

Ethnic Origin (please tick ☑)			
White	British	Black or Black British	Caribbean
	Irish		African
	Other White background		Any other Black background
Mixed	White and Black Caribbean	Other Ethnic	Chinese
	White and Black African		Any other ethnic group
	White and Asian	Other	Not Stated / do not wish to divulge
	Other mixed background		
Asian or Asian British	Indian	Is English your first language **Yes**☐ **No** ☐	
	Pakistani	If no which language:	
	Bangladeshi	Do you need an interpreter? **Yes**☐ **No** ☐	
	Other Asian background	What is your Religion?	

Online access – you can book appointments and order you medication online
Would you like to sign up to use the online service? Yes ☐ No ☐

Smoking Status

☐ I have **never** smoked tobacco
☐ I **currently** smoke _____ cigarettes/cigars/ounces a day
☐ I'm an **ex-smoker** of _____cigarettes/cigars/ounces a day, stopping _____ years ago.
☐ I would like to accesses your Support-to-stop smoking services

Alcohol (16years and over)	Score					Score
	0	1	2	3	4	
How often do you have 6 or more drinks if female, or 8 or more drinks if male on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected of you because of 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	
In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?	No		Yes, on one occasion		Yes, on more than one occasion	

Physical Activity (please tick ☑)
Which of the following best describes your current exercise participation?

Aerobic 0 times per week	☐	Aerobic 3+ times per week	☐	Enjoys light exercise	☐
Aerobic 1 times per week	☐	Enjoys Heavy exercise	☐	Avoid even trivial exercise	☐
Aerobic 2 times per week	☐	Enjoys Moderate exercise	☐	Exercise Impossible	☐

Dietary Preferences (please tick ☑) Please record your intake of fruit and vegetables

Less than 5 portions per day	☐	More than 5 portions per day	☐

BMI Please record height and weight. If unsure please use our height measure and scales

Height in cm		Weight in Kg	

Blood Pressure Please record your Blood Pressure on our machine

Systolic		Diastolic	

Allergies Please list any allergies:

CARER IDENTIFICATION Do you care for someone who is ill, Frail, Disabled or Mentally ill? If you would like support please complete this section

Details of the person you care for:
Name…….. Date of Birth……..
Address(If Different)…….……Post code……..
Telephone Number…… Relationship……...
GP Details……..

CHILDREN UNDER THE AGE OF 16 – NB New born babies will be registered with the same GP as mum.

Which School/Nursery does your child attend.....

Who does the child live with…….

Does the child have a social Worker? ☐ Yes ☐ No Social worker's Name……..

PATIENT PARTICIPATION GROUP

Would you like to join our Face to Face or Virtual patient participation group? The groups help us improve our service. See website (www.pioneermedicalgroup.co.uk/have-your-say) for details.

☐ Yes ☐ No, the Virtual Group ☐ Yes, the Face to Face Group

How would you like us to keep in contact with you?

Email: Yes☐ No ☐
Text messages for appointments, reminders and recall: Yes☐ No ☐
Text messages for results and health information: Yes☐ No ☐

If you sign up for the text service, you MUST inform us of any changes to your number in the future.

NAMED GP

All patients are allocated a named GP who will have overall responsibility for your care. However, you can consult with any GP or Nurse Practitioner. If you have a preferred named GP or want to know who your named GP is or then please let us know.

FOR OFFICE USE ONLY	Proof of Address Seen ( )
Registration Form(GMS) ( )	GP Allocated:…….
Practice Questionnaire ( )	Received by:……
Photo ID Seen ( )	Online access given Y/N