LEICESTER TERRACE HEALTH CARE CENTRE
ADULT NEW PATIENT REGISTRATION FORM

Welcome to Leicester Terrace Health Care Centre. Please complete all sections below.

PERSONAL DETAILS		
Surname:	Forename:	Title:
		DOB:
Address:	Postcode:	Male ☐ Female ☐
Tel Home: Preferred number ☐	Tel Mobile: Preferred number ☐	May we send you text messages on your phone? Mobile ☐ Home ☐ Please note that messages sent to a home number may be heard by other members of the household
Email address: May we contact you by email and/or send correspondence by email? Yes ☐ No ☐		

HEALTH DETAILS			
Height cm or ft/in:	Please use the scales and blood pressure machines in reception: Weight Blood Pressure		
Do you smoke? Yes ☐ No ☐	If **yes** how many per day? Cigarettes Roll-up Cigar Pipe	Would you like to give up smoking? Yes ☐ No ☐	Would you like help or assistance in stopping smoking? Yes ☐ No ☐
Are you an ex-smoker? Yes ☐ No ☐	If you are an ex-smoker when did you stop? Year:		
Please list any allergies:	Are you: A current member of the Armed Forces ☐ A Military Veteran ☐ A Reservist ☐		
Are you a carer (caring for someone in a non-professional capacity)? Yes ☐ No ☐ Do you currently have a carer? Yes ☐ No ☐			
Have you ever been involved with a Children's Social Service Team? Yes ☐ No ☐			
Do you have any information or communication support needs relating to disability impairment or sensory loss? Yes ☐ No ☐ If yes, we will be in touch with you further.			

Please state any serious illnesses, operations, accidents or disabilities:
Please state any family history of serious illness or inherited disease:
Have you lived outside of the UK within the last five years? Yes ☐ No ☐
Please list regular medications below and book an appointment with a Doctor when your registration is complete to discuss your medications:

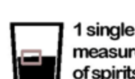
OTHER INFORMATION		
Nationality:	Main Spoken Language:	
Ethnic Group – please circle: British or Mixed British / English / Irish / Polish / White & Black African / Chinese / White & Asian / White & Black Caribbean / African Indian or British Indian / Caribbean / Pakistani or British Pakistani / Bangladeshi or British Bangladeshi Other Black, Asian, White or Mixed Background (Please state)		
Do you have an existing Summary Care Record? Yes ☐ No ☐	Would you like to opt out of the Summary Care Record? Yes ☐ No ☐	Would you like more time to make your decision? Yes ☐ No ☐
Do you want access to your on line medical record? Yes ☐ No ☐		
Would you like to nominate your chosen pharmacy so that your prescriptions can be sent through electronically? If so, please state the pharmacy of your choice:		
IF YOU WOULD LIKE A HEALTH CHECK PLEASE BOOK AT RECEPTION		

For Surgery use only. All information checked by:

AUDIT - C

Alcohol unit reference

One unit of alcohol



Drinks more than a single unit

Pint of “regular” beer, lager or cider

Pint of “strong” or “premium” beer, lager or cider

Alcopop or a 275ml bottle of regular lager

440ml can of “regular” lager or cider

440ml can of “super strength” lager

250ml glass of wine (12%)

75cl Bottle of wine (12%)

Questions	**Scoring system**					**Your score**
	0	**1**	**2**	**3**	**4**	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	0 to 2	3 to 4	5 to 6	7 to 9	10 or more	
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	

AUDIT C score	

Scoring:

- A total of 5 or more is a positive screen
- 0 to 4 indicates low risk
- 5 to 7 indicates increasing risk
- 8 to10 indicates higher risk
- 11 to 12 indicates possible dependence

Remaining AUDIT assessment questions

Questions	Scoring system					Your score
	0	1	2	3	4	
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 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 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	
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	
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	
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	

Total AUDIT score	

Scoring:

- 0 to 7 indicates low risk
- 8 to 15 indicates increasing risk
- 16 to 19 indicates higher risk
- 20 or more indicates possible dependence