REGISTRATION FORM

Please use this form to register in our practice.

Surname: _____

Maiden name (if applicable): _____

Given name: _____

Initials: _____

Date of birth: _____

Gender: male/female/other, _____

Street and number: _____

Postal code: _____

City: _____

Telephone: _____

2nd telephone number: _____

E-mail: _____

Citizen Service Number (BSN): _____

Health insurer: _____

Insurance number: _____

New pharmacy: _____

Previous GP: _____

Address previous GP: _____

I hereby consent to the exchange of my patient details with the hospital, pharmacy and the out-of-hours primary care.

I hereby consent to register and to transfer my patient file to the general practice.

Date Signature

_____ _____

BACKGROUND INFORMATION

It is important for your GP to have some more background information about you.

We will ask you a number of administrative questions as well as a few questions regarding major life events.

If you prefer not to answer a particular question, please leave this question unanswered and proceed to the next question.

Everything you have written down in this questionnaire will be protected by medical confidentiality and will therefore be treated as confidential.

Filling in this questionnaire will take approximately 5-10 minutes.

1.

What is your country of birth?

O the Netherlands
O Other, namely: _____

Both your country of birth and that of your biological parents are of medical importance when it comes to genetic disorders and risk factors.

2.

What is the country of birth of your biological mother?

O the Netherlands
O Other, namely: _____

3.

O **What is the country of birth of your biological father?**
O the Netherlands
O Other, namely: _____

4.

What is your marital state? *(multiple answers possible)*

O Single
O Not married but in a relationship, not living together
O Not married but in a relationship, living together
O Married (lawfully married or registered partnership)
O My partner is deceased
O Divorced
O Other, namely: _____

5.

Do the following diseases occur in your family?	Yes	No	Not known
a. Heart diseases in parents, siblings or children before the age of 60?			
b. Diabetes type 1 or type 2 in parents, siblings, or children?			
c. Melanoma (malignant mole) in parents, siblings or children?			
d. Colon cancer in parents, siblings or children before the age of 50?			
e. Colon cancer in more than one relative in the same family?			
f. Prostate cancer in father, brothers or sons before the age of 55?			

Do the following diseases occur in your family?	Yes	No	Not known
g. Ovarian cancer in mother, sisters or daughters?			
h. Breast cancer in parents, siblings or children before the age of 50?			
i. Breast cancer in more than one relative in the same family?			

6.

Please indicate the highest level of education that you have completed

O No education / no education completed
O Primary education
O Practical education
O Lower general secondary education
O Higher general secondary education
O Pre-university education
O Secondary vocational education a
O Higher vocational education
O University education
O Other: _____

7.

What is your profession? _____

8.

How many hours per week are you in paid employment? hours per week

9.

Do you smoke cigarettes / cigars / pipe?

O No, I have never smoked -> please proceed to question 13
O No, I quit smoking as of (year) _____
O Yes

10.

What do you smoke / What did you smoke? *(multiple answers possible)*

O Cigarettes
O Cigars
O Pipe

11.

How many years have you been smoking / How many years did you smoke:

years

12.

How many cigarettes / cigars / pipe do you smoke / did you used to smoke on average?

_____ a day/week/month/year

(Please delete as appropiate)

13.

Do you drink alcohol?

O No, I have never drunk alcohol -> Please proceed to question 15
O No, not in the past 12 months
O Yes

14.

How many glasses of alcohol do you drink / did you used to drink on average?

_____ glasses a day/week/month/year
(Please delete as appropiate)

15.

Do you use drugs?

O No, I have never used drugs → Please proceed to question 17
O No, not in the past 12 months
O Yes

Which drugs do you use / did you use (multiple answers possible)

O Weed
O Ecstasy (XTC)
O LSD
O Magic mushrooms
O Cocaine
O Heroin
O Other, namely _____

16.

How many days a week do you use / did you use drugs on average?

_____ days a week/month/year
(Please delete as appropiate)

The following questions deal with major life events

17.

Have you ever been divorced?

O No
O Yes, number of times _____

18.

Have you ever had to deal with an emotional event such as the death of someone

O No
O Yes, namely
  O Partner
  O Parent(s)

- O Child
- O Close friend
- O Other, namely _____

19.

Are you or have you ever been the victim of sexual abuse, physical or psychological violence?

- O No
- O Yes

20.

Are you at present pregnant?

- O No
- O Yes
- O I am not sure
- O Not applicable -> Please proceed to question 22

21.

How often were you pregnant?

_____ times pregnant

22.

How many biological children do you have?

_____ children

23.

Do you have a responsibility of care for children of whom you are not the biological parent?

- O Yes, please clarify: _____
- O No

24.

Do you have any further (additional) remarks that are of importance to your GP?

_____

_____

_____

_____

_____

_____

If you have any questions relating to this questionnaire or if you wish to talk about something, please do not hesitate to make an appointment with your GP.

Thank you very much for your time in filling in this questionnaire.