You are invited to have a consultation with a health care professional within 6 months of registering.

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| ABOUT YOU |
| Surname: |  | Forename(s):  |  |
| Gender: |  | DOB: |  |
| Address: |  |
|  |  | Postcode: |  |
| Email: |  | Occupation: |
| Home phone: |  |
| Mobile: |  | Work Phone: |  |

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| NEXT OF KIN |
| Name | Relation to you | Contact Details |
|  |  |  |
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| ETHNICITY |
| **White**  |
| British Group  | [ ]  | Irish  | [ ]   | Other White Background | [ ]  |
| **Mixed**  |
| White & Black Caribbean  | [ ]  | White & Black African  | [ ]  | White & Asian  | [ ]  [ ]  | Other MixedBackground | [ ]  |
| **Asian or Asian British**  |
| Indian  | [ ]  | Pakistani  | [ ]  | Bangladeshi  | [ ]  | Other AsianBackground | [ ]  |
| **Black or Black British**  |
| Caribbean  | [ ]  | African  | [ ]  | Other BlackBackground | [ ]  |
| **Chinese or other ethnic Group**  |
| Chinese  | [ ]  | Any Other  | [ ]   |
| First Spoken Language:  |  |
| Do you require an interpreter: |  |

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| LIFESTYLE |
| How much do you weigh? | St | Ibs | or | Kg |
| How tall are you? | Ft | ins | or | cm |
| Do you smoke? | NO | [ ]  | YES | [ ]  | CIGARETTES | [ ]  | E-CIGARETTES | [ ]  | HOW MANY A DAY ……………………… |
| Pipe Smoker | [ ]  | Rolls own | [ ]  | ………………..Grams per week |
| Have you ever smoked? | NO | [ ]  | YES | [ ]  | When did you stop? |  |
| How many did you smoke? |  |
| Do you exercise?  | NO | [ ]  | YES | [ ]  | MODERATLEY | [ ]  | HEAVILY | [ ]  |

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| FAST ALCOHOL SCREENING  |
| How much alcohol do you drink? |  | Units per week |
|  | *(1 unit = ½ pint of beer, 1 glass of wine or measure of spirits)* |
| For the following questions please circle the answer which best applies**1 drink = ½ pint of beer or 1 glass of wine or 1 single spirits**  |
| 1. *MEN: How often do you have EIGHT or more drinks on one occasion?*

*WOMEN: How often do you have SIX or more drinks on one occasion?* |
| 0Never | 1Less than monthly | 2Monthly | 3Weekly | 4Daily or almost daily |
| 1. *How often during the last year have you been unable to remember what happened the night before because you had been drinking?*
 |
| 0Never | 1Less than monthly | 2Monthly | 3Weekly | 4Daily or almost daily |
| 1. *How often during the last year have you failed to do what was normally expected of you because of your drinking?*
 |
| 0Never | 1Less than monthly | 2Monthly | 3Weekly | 4Daily or almost daily |
| 1. *In the last year has a relative or friend, doctor or health worker been concerned about your drinking or suggested you cut down?*
 |
| 0Never | 1Less than monthly | 2Monthly | 3Weekly | 4Daily or almost daily |

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| HEALTH CONDITIONS |
| *Has you ever been diagnosed with:* | YES | NO |
| Asthma | [ ]  | [ ]  |
| Epilepsy | [ ]  | [ ]  |
| Diabetes | [ ]  | [ ]  |
| Deafness/hearing impairment | [ ]  | [ ]  |
| Blindness/visual impairments | [ ]  | [ ]  |
|  |
| *If you have any other conditions, please give details below:* |
| Learning/ behavioural difficulties |
|  |
| Heart/Lung/Kidney/Liver problems |
|  |
| Other Medical problems, including past operations |
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| ALLERGIES/ INTOLERANCES |
| *Please list any drugs, food or other substances to which you are allergic (i.e. develop an rash/swelling/anaphylactic shock) or drugs to which you are intolerant (i.e. side effects such as diarrhoea or nausea)*  |
|  | Allergy / intolerant (please circle) |
|  | Allergy / intolerant (please circle) |
|  | Allergy / intolerant (please circle) |
|  | Allergy / intolerant (please circle) |

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| FAMILY HISTORY  |
| *Please indicate if either of your immediate family have been affected by:* |
|  | YES | Family Member | Age at onset |
| Heart attack/ Angina | [ ]  |  |  |
| Stroke | [ ]  |  |  |
| Diabetes | [ ]  |  |  |
| Hypertension (high BP) | [ ]  |  |  |
| High Cholesterol | [ ]  |  |  |
| Asthma | [ ]  |  |  |
| CancerType of Cancer ………………………………..………………………………………………………………………………………………………… | [ ]  |  |  |

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| MEDICATIONS |
| *Please provide a list of any repeat medications you are taking:* |
| **You will need to see a GP before we can issue any medications that were on repeat at your previous GP** |
| 1. |  |
| 2. |  |
| 3. |  |
| 4. |  |
| 5. |  |

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| PRESCRIPTIONS |
| *Binscombe Medical Centre is an* ***electronic prescribing practice****. If you would like to nominate a pharmacy for this service you can do so through your chosen pharmacy. You can find a list of local pharmacies on the NHS Choices website at www.nhs.uk.* |

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| CARERS |
| *(Do you look after someone who is dependent on you some, or all of the time?)* |
| Are you a carer? | YES [ ]  | NO [ ]  | If yes, please ask for a carers form when you hand in this form |

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| SUMMARY CARE RECORD |
| **This practice participates in** the national Summary Care Record programme which enables each patient to have a summary of their key medical information held securely on the NHS central database, known as the NHS Spine. This summary record could be used in an emergency if you needed treatment when access to the medical record held by your GP was not available; for example if you call the doctor out of hours. You will always be asked to give permission for this record to be viewed and you have the right to decline. If you decide to have a Summary Care Record it will contain important information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines that you have had. |
| If you ***do not*** wish to have a summary care record, please indicate below |
| I do not wish to have a summary care record ……………………………………………………….[ ]  |

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| FOR WOMEN |
| Date of last Cervical Smear: |  | Result: |  |
| *If you are due for a smear please ask the receptionist to make an appointment with the nurse or doctor to have this done. It is recommended that you should have a smear done every 3 years from age 25 – 49 and every 5 years from age 50 -64.* |
| When was your last Mammogram: |  | Result: |  |
| *You will be invited to have a mammogram every 3 years from age 50 till 65, if you have any queries with regards to this please ask your doctor.* |
| *Contraceptive advice can be provided by any of the doctors during routine surgery or in our family planning clinic.* |

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| CONSENT FOR COMMUNICATION FROM US |
| At Binscombe, we use texts and emails to keep you informed about your care and the practice. |
| **If you have provided a mobile phone number in this questionnaire it will automatically be used to enrol you in our text service which allows you to receive messages about your care such as appointment reminders and vaccination invitations.****It may also be helpful to contact you by text message regarding other aspects of your care.** |
| If you **DO NOT** wish to receive these text messages, please tick this box | [ ]  |
| *Please be aware that if you opt-out you will not receive appointment reminders* |
| Are you happy for us contact you via email? | YES [ ]  | NO [ ]  |
| *You may opt in or out of communication services at any time by contacting the surgery.* |
| *Do you have any disability or individual need that might affect how we should contact you? (e.g.. hearing impairment, visual impairment, difficulty readying) Please detail below:* *……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………*  |

**Under NHS Regulations, we cannot accept registrations that are incomplete.**

To prevent a delay in your registration being accepted please read the guidance below before filling in the attached forms:

* All patients will need to provide a copy of their Passport/ Visa and a copy of a utility bill for proof of address
* If you are from abroad, we will require Date of Entry to the UK
* If previously resident in the UK we will also require Date of Leaving UK and Date of Entry
* Please provide full details of your previous address including postcode. This is particularly important if previous address was in London.

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|  Signature: |  | Date: |  |
| Print Name: |  |  |  |