**KINGSDALE & PERRY PARK MEDICAL CENTRE**

Do you need help filling this form out? If so please speak to a member of staff.

TITLE: MR / MRS / MISS /MS / DR / OTHER (Please delete as necessary) **Please complete in BLOCK CAPITALS**

**SURNAME** ..............................................................................................................................................................................

.

**FIRST NAME**: …………………………………………………… MIDDLE NAME (S): ……………………………………………..

MAIDEN NAME(if applicable)…………………………………...................................................................................................

**CURRENT ADDRESS**……………………………………………………………………………………………………………………………….

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**PREVIOUS ADDRESS**…………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………….

**OCCUPATION** ………………………………………………...

**DATE OF BIRTH**: …………………………………………………….. ……………………………………………………………….

**HOME TEL. NO**: ……………………………………………………. **MOBILE**: ……………………………………………………..

**EMAIL ADDRESS**: ……………………………………………………………………………………………………………………

**MAIN LANGUAGE**: …………………………………………………….. **INTERPRETER NEEDED**: …………………………….

**NATIONALITY**: ……………………………………………….. **ETHNIC ORIGIN**…………………………………………………….

**IF YOU HAVE ARRIVED IN THE COUNTRY IN THE LAST 10 YEARS, WHAT DATE DID YOU ARRIVE**?

……………………

**EMERGENCY CONTACT DETAILS:**

**NAME**……………………………………………………….

**TELEPHONE NUMBER**……………………………………

Do you give this person permission to discuss your medical records? YES or NO

DO YOU HAVE A CARER? **YES / NO**

IS THE CARER REGISTERED AT THIS SURGERY? **YES / NO**

IF YES, PLEASE GIVE DETAILS:

NAME: .........................................................................................................................................................................................

ADDRESS:..................................................................................................................................................................................

……………………………………………………………………………………………………………………………………………….

TELEPHONE...............................................................................................................................................................................

**PLEASE CONFIRM THAT YOU AGREE TO YOUR CARER BEING GIVEN PERMISSION TO DISCUSS YOUR MEDICAL MATTERS WITH THE PRACTICE. *(\*Please delete the statement that does not apply).***

**\*I DO/DO NOT (delete as necessary) GIVE PERMISSION FOR MY CARER NAMED ABOVE TO HAVE PERMISSION TO DEAL WITH MEDICAL MATTERS ON MY BEHALF.**

ARE YOU A CARER FOR ANYONE? **YES / NO**

IS THE PERSON REGISTERED AT THIS PRACTICE? **YES / NO (**IF YES, PLEASE GIVE DETAILS)

NAME: ...................................................................................................................................................................................

ADDRESS….........................................................................................................................................................................

………………………………………………………………………………………………………………………………………

TELEPHONE NUMBER: .......................................................................................................................................................

**PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR PERSONAL CIRCUMSTANCES. IF YOU ANSWER YES PLEASE PROVIDE BRIEF DETAILS:**

**SMOKING HISTORY**

Are you a

Non Smoker

Ex-Smoker

When did you stop smoking?

Current Smoker

How many per day?

Would you like help to stop smoking?

**ALCOHOL SCREENING**

**Please complete the Alcohol Screening table below. Please select the answer which best applies to your drinking in the last year.**

**1 drink is equal to 1 pint of beer, 1 standard glass of wine or 1 single spirit**

SCORE

SCORING SYSTEM

QUESTIONS

**O**

Daily or almost

daily

Weekly

Monthly

Monthly or less

Never

In the last year, has a friend or relative, Doctor or co-worker been concerned about your drinking or suggested you cut down?

Daily or almost daily

3

Weekly

Never

Monthly or less

Monthly

Daily or

almost

daily

Weekly

Monthly

Monthly or less

Never

Daily or almost

daily

Weekly

Monthly

Monthly or less

Never

How often in the last year have you failed to do what was normally expected of you because of drinking?

How often during the last year have you been unable to remember what happened the night before because you had been drinking?

How often do you have SIX or more drinks for women and EIGHT for men on one occasion?

4

2

1

0

**PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR MEDICAL HISTORY**

**PLEASE PROVIDE BRIEF DETAILS:**

Do you have any allergies or current

conditions? If yes, Please provide brief details:

Are you currently taking medication? Please provide a copy of your most recent prescription

Have you had surgery in the last twelve months?

If yes, Please provide brief details:

**LONG TERM HEALTH ISSUES**

The Electronic Prescriptions your.

Do you have any long term health issues? eg Asthma, Diabetes, COPD, Mental Health Learning Disabilities etc. If so please indicate below

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|  |

**Do you have a support worker or carer?**

**Name: ……………………………………………………………………..**

**Contact No: -----------------------------------------------------**

**Do you take any medication for this/these issues? Please indicate below**

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**PHARMACY – WHICH PHARMACY WOULD YOU LIKE TO USE?**

Name of Pharmacy…………………………………………………………….

Address of Pharmacy………………………………………………………….

**PLEASE IDENTIFY IF YOU OR ANY FAMILY MEMBERS HAVE SUFFERED WITH ANY OF THE FOLLOWING CONDITIONS. If yes, please provide relationship**

Heart Conditions/Disease

Cancer

High Blood Pressure

Death Before the Age of 50

Asthma

**LATENT TUBERCULOSIS INFECTION SCREENING**

We are screening for latent tuberculosis (TB) in patients:

Are you between 16-35 years of age?

Have you arrived in the country in the last 5 years and never been screened or treated for TB?

Born in a country with a high risk of TB or spent more than 6 months in a country with a high risk of TB in the past 5 years

If you answer **YES to ALL three questions** then please can you contact the practice to make an appointment for a free latent TB blood test.

**PATIENT ACCESS**

**To allow us to offer an accessible service to all our patients please provide answers to the following questions. If you answer yes, please provide brief details.**

If yes please provide brief details:

Do you require sign language to communicate with others? (BSL interpreters can be provide on request)

Are you deaf

Are you registered disabled?

How is it best to communicate with you?

Are you hard of hearing?

:

Are you registered blind or require assistance negotiating daily

tasks?

Do you have eye sight problems?

If yes please provide details:

Do you require braille or another method of reading documents?

If yes do you communicate with sign language or require any other assistance to communicate with us?

Do you have any form of speech

Impediment or require assistance with verbal communication?

**You can now book appointments, order repeat prescriptions and even access your GP records online. It’s quick, easy and your information is secure.** For more information about keeping your healthcare records safe and secure please visit our website: www.nhs.uk/patientonline

|  |  |  |  |
| --- | --- | --- | --- |
| Surname |  | | |
| First name |  | | |
| Date of birth |  | | |
| Address |  | | |
| Postcode |  | | |
| Email address |  | | |
| Telephone number |  | Mobile number |  |

I would like to have access to the Online Services I have selected above. I confirm that I understand the importance of keeping my details safe and I will inform the practice if I have any concerns or change my mind.

When you have handed in your registration form it will usually be 7-10 days before registration is complete**. If you are on any current medication please ensure that you have enough to carry you through this period by speaking to your current surgery as you will need to be seen by a Doctor/Nurse before any medications can be issued.** A welcome letter will be sent to confirm registration at which point you may be invited to attend for an NHS Health Check.

Signature of Patient…………………………………………………………………………

Date………………………….

For office use only:

Received by: ……………………………………………………………………………………………………………….

Date: ……………………………………………………………………………………………………………….

GP Review: …………………………………………………………………………………………………………………

Comments

Date: ………………………………………………………………………………………………………………....