Surgery Registration Application

Please complete all applicable details in BLOCK CAPITALS.

Full Name	**Date of birth**
Address	

Home Phone Number	**Work Number**	**Mobile Phone Number**

Email address

Next Of Kin : **Relationship to you:**

Name

Number

Height	**Weight**

Ethnicity

☐ Bangladeshi ☐ Black African ☐ Black Caribbean ☐ Black Other ☐ Chinese ☐ Indian

☐ Pakistani ☐ Vietnamese ☐ White ☐ Other

Main language spoken _____ **Translator required** ☐ Yes ☐ No

Are you a carer?

If you spend time looking after a relative; child; partner or friend who is frail, disabled or has a mental health difficulty, you are a carer

☐ Yes ☐ No .

Name of person being cared for: Age:

Are they registered at this surgery? ☐ Yes ☐ No

Do you suffer from

☐ Asthma

☐ Diabetes

☐ Epilepsy

☐ Heart Disease

☐ High blood pressure

☐ Any other condition which requires you to take life long medication

Please list any drug allergies: *Dispensary*

Do you take regular medication? ☐ Yes ☐ No

Please see a member of staff at dispensary to discuss your medication requirements and bring along a copy of your repeat medication.

PLEASE SEE ATTACHED ABOUT THE ELECTRONIC PRESCRIPTION SERVICE

Nominated Pharmacy: ……

Family History In A Close Relative

Please tick if a close relative has suffered from any of the following conditions and indicate their relationship to you for example Uncle.

High Blood Pressure	Heart Disease under 60 years of age
Stroke	Diabetes
Asthma	Colon Cancer
Breast Cancer	

Consent To Hold Your Records

The Practice needs to hold your medical records on the premises in order to give you the best medical care possible. We keep your records on the computer as well as holding your paper notes. All of our patient's medical records are covered by the Data Protection Act 1998. This means that a third party cannot access your records without your written consent. We may use your mobile phone to contact you for appointments reminders and cancellations, health promotions, surgery updates and surveys. If you did not wish to participate please tick the box and we shall opt you out of these preferences ☐

Summary Care Record

Your summary care record is an electronic record of important information about your health and is available to healthcare staff providing your NHS care in England, for example in A&E. This means if you ever become ill and need urgent or out of hours treatment outside of the surgery the clinicians that treat you will have immediate access to important healthcare information about you. The information included in your summary care record is your current medication, allergies you suffer from and any bad reactions to medications you have experienced.

If you do not want this to happen then please ask reception for an Opt Out Form

SIGNATURE _____ DATE _____

PLEASE TURN OVER

Tobacco Use

Never Smoked ☐ Current Smoker ☐ Ex-Smoker ☐ Stopped: _____

Cigarettes _____/day Roll-ups _____oz/week Cigars _____/day Pipe _____oz/week

If you are a smoker please consider making an appointment with the nurse to discuss smoking cessation

Alcohol Use

Alcohol intake units per week = _____ 1 unit = ½ pint of beer; 1 measure of spirit or a small glass of wine

PART 1: Questions	**Scoring system**					**Your score**
	0	**1**	**2**	**3**	**4**	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 8	10+	
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	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

Score: ( )

Remaining questions (only answer if score in Part 1 is 5 or higher)

PART 2: 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	

Scoring:
Total: 0 – 7 Lower risk 8 – 15 Increasing risk 20+ Possible dependence

( )

Please return your completed forms to Reception.

Thank you.