SHOTFIELD MEDICAL PRACTICE

HEALTH DATA& NEW REGISTRATION FORM (OVER 16 YRS)

**PLEASE ENSURE ALL FORMS ARE COMPLETED IN FULL & CLEARLY USING BLOCK CAPITALS**

Present Surname: ……..………………………….. Forenames: ………..……..………………… Title: Mr/Mrs/Miss/Dr \*

Previous Surname: …………….…………….……. Date of Birth: …………….………..………. Sex: M / F \*

Surname at Birth: ……………….………………… Marital Status: ………………...………….. NHS No: …………….………..

Present Address (incl. Postcode): ……………………………………………………………………………………………………..

Telephone Nos. - Home: …………………………. Work: …………………………….. Mobile: ……………………………

Email Address: ………………………………………………………………………………

***Note: we may use your email address or your mobile number to contact you so providing these & signing this form acts as a consent for us to do this. Please ensure your email & mobile phone number are always kept up-to-date.***

Ethnic Origin: ***Please complete Appendix B regarding ethnicity attached***

Date of Entry Into The Country For Permanent Residence (if applicable) : ……………………………………………………….....

Next of Kin – Name: …………………………………. Address: …………………………………………………………………..

Tel. No: ………….……………………………………. Relationship: ……………………………………………………………..

Previous GP – Name: ………………………………… Address: …………………………………………………………………...

Do you have any information sharing or communication issues, if so please give details below? YES / NO\*

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

Are You A Carer? Yes / No\* If Yes, Who Do You Care For? …………………………………………………………………..

Do You Have A Carer? Yes / No\* If Yes, Who Cares For You? Name: ………………………………………………………..

Address: ……………………………………………………………… Relationship: ………………………………………………

***If you are a carer we would like to support you and refer you to suitable services, please ask at reception for a separate form***

Immunisation Status - Please give latest dates. Book an appointment to see the nurse if you need an update.

Tetanus: …………..….…………..………………………………. Polio: …………………………………………………………..

Family History - Please indicate if there is a family history of any of the following, and give the family member details.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Diabetes | Raised BP | Heart Disease | Asthma | Mental Illness |
|  |  |  |  |  |

Other: …………………………………………………………………………………………………………………………………

Previous History - If you have had any previous illness, accident, operation or hospital admission, please supply details below.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| DATE(S) | CONDTION | HOSPITAL | TREATMENT | FOLLOW UP |
|  |  |  |  |  |

Are you currently attending hospital as an outpatient or on the waiting list for an inpatient/day-case procedure? Yes / No\*

If YES, please give details ……………………………………………………………………………………………………………

Are you allergic to any foods/medicines? Yes / No\* If YES, please give details: …………………………………………………

Drinking Pattern – Do you currently drink alcohol? Yes/No\* ***please also complete appendix A attached for alcohol screening***

Smoking Pattern – Do you currently smoke? Yes/No\* If YES, go to question A below. If NO, go to question B below.

1. How long have you been smoking? …………… What do you smoke/how many per week? …………………………………

B. Have you ever smoked? Yes/No\* If YES, what did you smoke/how many/when did you stop? ………………………………

***See the leaflet about LiveWell which includes advice on how to give up smoking if you are currently a smoker (code 8CAL)***

Current Height: ……………………………………………… Current Weight: …………………………………………………

Present Medication – Please give details of any prescribed repeat medication you are currently taking:

|  |  |
| --- | --- |
| Name of Medicine | Dosage |
|  |  |

Females only:

Have you had a cervical smear in the last 3 yrs? Yes/No\* If yes, where/when/result: ……………………………………………..

Have you had a hysterectomy? Yes/No\* If YES, when/where was this? ………………………………………………………...

Contraception – Please indicate which method of contraception you currently use:

Oral pill\* (type) ………….…. Cap\* Sheath\* Vasectomy\* Sterilisation\* IUCD\*(date fitted/type) ………….…….……….…

If applicable, how long have you been taking the oral contraceptive pill? ………………………………….…………………..……

Have you experienced any problems with your present method of contraception? Yes/No\*

If yes, please give details: ……………………………………………………………………………………….………………….…

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

\* delete or complete as appropriate

Please note: we require 1 item of ID in your own name & giving the full address at which you are registering to be submitted with all other paperwork. This item of ID should be dated in the last 3months (i.e. council tax bill, tenancy agreement or bank statement), items such as a driving licence, utility bill or passport **do not** qualify. Do not submit **any** paperwork until all items are entirely complete & the ID is also available. Once processed this item of ID provided will be destroyed and will not be maintained by the practice or in your records.

**For use by practice rec staff only:**

ID Item Provided: …………………………………………….….. Dated: ………………… Seen By: …………………………..

## Important Notes (please read):

* You will not normally be able to see a clinician until your registration is complete.
* If you require repeat medication immediately after registration without seeing a doctor please obtain full details from your previous GP & pass it to the receptionist with your written repeat prescription request. We will be unable to issue repeat prescriptions without an appointment with a doctor if this information is not provided. **If you previously nominated a pharmacy in another area for the electronic issue of prescriptions this will need to be changed, please complete a nomination form at the pharmacy of your choice, or ask for one at reception.**
* Please ensure your personal information is always kept up to date and inform us immediately of any changes.
* We have an online service for booking routine appointments with the doctors & ordering standard items of repeat medication (not changes), please ask at reception for more information on how to register for this service
* Summary Care Record – if you **DO NOT** wish to have your basic health information uploaded to the national summary care record (SCR) please complete the enclosed form & return it to us with your paperwork. The basic information includes medications, allergies and adverse reactions only, no other data would be included in the upload. If you **do not object** to this upload you **do not** have to complete any paperwork, the upload will then take please automatically

***Please note: we DO NOT add patients to the organ donation register. If you do wish to join the NHS organ donor please do so online at*** [***www.organdonation.nhs.uk***](http://www.organdonation.nhs.uk/) ***or by telephone to 03001232323****.*

***For practice admin use only:***

Informing Patient of Named Accountable GP 67DJ Patient allocated named accountable GP 9NN60