Broseley Medical Practice

Patient Registration Form

Welcome to Broseley Medical Practice. We are pleased that you have chosen us as your medical practice. This Form is very important – please complete the information below, and return this form to reception before you leave the Surgery, as we may not receive your medical records for some time, we would also advise you to book your medical examination at your earliest convenience. All your information is kept strictly confidential within the NHS and not shared or used without your consent.

PLEASE COMPLETE ALL DETAILS AS FULLY AS POSSIBLE

BASIC DETAILS

Title e.g Mr, Mrs, Miss etc.		**Occupation**	
Surname			
Previous Surname			
Forenames			
Preferred name (if different to above)			
Date of Birth		**Place of birth**	
Your current home address including postcode			
Home phone number			
Mobile phone number			
We send automatic text message reminders the day before your appointments with us and you can cancel your appointments by text we may also send you Health campaign text messages. To OPT OUT of this free service tick this box ☐			
E-mail address			
***Patient Access** is an internet service through our website that lets you book and cancel appointments on-line and also order your repeat medicines. If you would like to register for this service please speak to a member of our Reception Team.*			
Specific needs: Please detail below any specific needs you have so the practice can ensure they are identified and accommodated:			
Please state any Sensory Impairment you have: (i.e speech, Hearing, Sight) Please give details (i.e wear hearing aid, need large Print)			
Are you an Assistance Dog user?			
Please state any Physical or Mental disabilities you have :			
Please state any requirements you have to be able to access the practice premises:			

INFORMATION SO WE CAN TRACE YOUR MEDICAL RECORDS

NHS number	
Your previous address including postcode	
Previous GP Name Address	
Have you been registered here before?	☐ No ☐ Yes If so, when?
If you have moved from abroad, date of arrival in the UK	
Next of kin Name Address Phone number Relationship to you	Are they your carer? Yes / No
If ex-armed forces: Address before enlisting Dates of service (from/to)	
Special Circumstances Please tick if any of these apply to you	☐ I have a carer ☐ Housebound ☐ I am a carer (non-professional) ☐ Other Please give details

HEALTH AND LIFESTYLE

Smoking Status Please complete if you are 12 years or older	☐ Never Smoked ☐ Ex-smoker – Date stopped: ☐ Cigarette Smoker: per day ☐ Cigar Smoker: per day
Would you like advice on giving up smoking? *The surgery offers a stop smoking service, run by help 2 quit. Please ask reception for more details or if you would like to book an appointment.*	
Alcohol Use How many units of alcohol do you drink in a typical week?	A unit of alcohol is approximately ½ pint standard (3.5%) beer / ⅓ pint of premium (5%) beer / 125 ml of wine / 25ml of spirits.

Alcohol Use Screening *Please circle your answer to each question*	**0**	**1**	**2**	**3**	**4**	**Your Score**
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?	Never	Less than monthly	Monthly	Weekly	Daily	
How often during the last year have you been unable to remember what has happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily	

How often during the last year have you failed to do what was normally expected of you because of drink?	Never	Less than monthly	Monthly	Weekly	Daily	
In the last year has a relative or friend or a doctor or other health worker be concerned about your drinking suggested you should cut down?	No	Yes – on 1 occasion *(score 2)*		Yes – on more than 1 occasion (score 4)		

ABOUT YOR PAST MEDICAL HISTORY

Medical History Please tick if you have/ have had any if the following conditions			
Have you had any significant medical problems / diseases / illnesses / operations in the past? If yes please state the year(s) when you were first diagnosed.	☐ Asthma/COPD ☐ Cancer ☐ Diabetes ☐ Epilepsy ☐ Heart Disease ☐ High Blood Pressure ☐ Rheumatoid Arthritis ☐ Stroke ☐ Other Please give details		
Immunisations Please list any recent immunisations e.g. flu, pneumococcal etc.			
Please list all your current medications Ensure you include inhalers, dressings and appliances. (or you can attach a copy of your previous surgery's repeat medicines list if you prefer – tick here)		Dose / Strength e.g. 20mg tabs	Times per day
We will send your prescriptions to your preferred local pharmacy where you can collect your medicines at your convenience. Which pharmacy would you like to use?			
Do you have any allergies?			

Family History Please give details of any significant Family History	

PHYSICAL DETAILS

Weight		**Height**	

ETHNICITY AND LANGUAGE

Ethnic Origin Knowing your ethnic origin is important for some of our tests and may affect which medicines work best for you.	☐ *White* ☐ British ☐ Irish ☐ Other ☐ *Asian / Asian British* ☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Other ☐ *Black / Black British* ☐ Caribbean ☐ African ☐ Other ☐ *Other/Other British* ☐ Chinese ☐ Other
First Language	
Do you need an interpreter?	

Women Only			
What was the date of your last smear?		**What was the result of the smear?**	
Method of contraception if used		**Date of last Mammogram (if applicable)**	
Have you had a Hysterectomy?		**Have you been sterilised?**	

Summary Care Records

Your Summary Care Record is a short summary of your GP medical records. It tells other health and care staff who care for you about the medicines you take and your allergies. This means they can give you better care if you need health care away from your usual doctor's surgery.

SCRs improve care, but if you don't want to have one you can opt out.

I would like to opt out of summary care records
Patients Signature

Thanks for completing this form, for more information about the practice please refer to our practice leaflet or see our website: www.broseleymedicalpractice.co.uk

For Surgery Use Only

Proof of Identity and Address provided			
Birth Certificate	Driving Licence	Passport	Utility Bill
Other Please specify			

Form accepted & checked by:

Patient informed of named accountable GP:

Details of new patient check appointment made:

Data template completed by:

Patient registered as active on EMIS by: