Welcome to our practice. Please help us to help you by filling out this form.

Please complete a separate form for each member of the family.

For more information about the Practice please visit our website:

[**www.bugbrookemedicalpractice.co.uk**](http://www.bugbrookemedicalpractice.co.uk)

|  |  |
| --- | --- |
| **Title** | **DATE OF BIRTH** |
| First Name | Surname (family name) |
| Occupation | Previous Surnames |
| YOUR FULL ADDRESS AND POST CODE  | Home Telephone Number |
| Work Telephone Number |
| Mobile Telephone Number |
| Email Address |
| Ethnic Origin | 1ST Language |
| **Weight** | **Height** | Religion |
| **Blood Pressure** |  |  |
| Do you want to register for on-line ordering of repeat medication? Yes/No |  |

**We have a HEALTH CHECK MACHINE at the back of reception, that will help you complete the questions above, if unsure, please ask at reception**

**MEDICAL INFORMATION**

|  |  |
| --- | --- |
| Smoker –How many cigarettes do you smoke a day? | Number: |
| Past Smoker – When did you give up | Date: |
| Never smoked | Please tick |
| We advise all patients to stop smokingWould you like smoking cessation advice? | Yes/No |

|  |
| --- |
| **Which of the following best describes the exercise that you do (please tick 1 option)** |
| I avoid exercise |  | I take occasional light exercise  |  |
| I take regular moderate exercise  |  | I take regular heavy workouts  |  |

**Please tell us about any medication YOU are currently taking. Please supply us with your repeat prescription slip or the boxes with the label on with instructions, and please request a month’s supply before leaving your old practice.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication** | **Strength** | **Dose** | **Is it on regular repeat?** |
|  |  |  | Y/N |
|  |  |  | Y/N |
|  |  |  | Y/N |
|  |  |  | Y/N |
|  |  |  | Y/N |
|  |  |  | Y/N |
|  |  |  | Y/N |

**Please list any long term medical conditions YOU have:**

|  |  |
| --- | --- |
| **Details** | **Year** |

**Please tell us of any disabilities and specific needs you have:**

**Please tell us about any allergies that you have:**

**Family History**

**Please tick if you or your close family (ie parents, brother and sisters) have any of**

**the following:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **You** | **Parents** | **Siblings** | **Age of onset** |
| Asthma |  |  |  |  |
| COPD |  |  |  |  |
| Diabetes |  |  |  |  |
| High Blood Pressure |  |  |  |  |
| High Cholesterol |  |  |  |  |
| Heart Attack |  |  |  |  |
| Stroke |  |  |  |  |
| Cancer (type) |  |  |  |  |
| Epilepsy |  |  |  |  |
| Other inherited diseases |  |  |  |  |
| Mental Health problemseg Anxiety/Depression |  |  |  |  |

**Carers**

|  |  |  |
| --- | --- | --- |
| Do you care for someone? | Yes/No |  |
| If yes please give details | Name: | Relationship: |
| Does someone care for you? | Yes/No |  |
| If yes please give details | Name: | Relationship: |

**Female Patients**

|  |  |
| --- | --- |
| Have you ever had a cervical smear, (if yes what was the date of your last smear).  | Yes/NoDate of last smear |
| What form of contraception do you use? |  |

|  |
| --- |
| **Do you drink alcohol? Yes/No** |
| How often do you have a drink of alcohol?Please tick relevant box | Never | Monthly or less | 2-4 times per month | 2-3 times per week | 4+ times per week |
| How many standard alcoholic drinks do you have on a typical day when you are drinking?Please tick relevant box | 1-2 | 3-4 | 5-6 | 7-8 | 10+ |
| How often do you have 6 or more alcoholic drinks on one occasion?Please tick relevant box | Never | Less than monthly | Monthly | Weekly | Daily/almost daily |

|  |  |
| --- | --- |
| Have you ever served in the British Armed ForcesIf Yes, in what capacity did you serve: This information helps us prioritise your NHS treatment if you suffer a medical condition, caused by your duties while serving.  | **Yes/No** |

**Summary Care Record**

All new patients will be asked if they wish to have a Summary Care Record, this is an electronic record, taken from your GP record, which will give the Out of Hours and the Accident and Emergency Doctors access to the Medications you take, any Allergies you have and any Adverse Reactions you have to medications. This will allow health care staff to provide you with safer care in an emergency, when the practice is closed or when you are away from home in another part of England.

**Please tick one of the options below:**

|  |
| --- |
| Express Consent – Yes I would like a Summary Care Record |
| Express Dissent – No I do not want a Summary Care Record**Please note:** If you do not want a Summary Care Record, you will need to complete an opt-out form, please ask at reception. Children will automatically have a Summary Care Record made for them, if you do not want your child to have a Summary Care Record you will need to complete an opt-out form on behalf of your child and return it to us. |

We are also able to offer a SMS text message service to your mobile phone, for appointment reminders and blood test results.

We need to register you for the SMS text message service and have your correct mobile phone number. This is a free service.

**Please tick one of the options below:**

|  |  |
| --- | --- |
| Please register me for the SMS text service ( I will advise the practice of any change to my mobile number) |  |
| I do not want to register for the SMS text service |  |

**ALL PATIENTS**

**Signature …………………………………………………………… Date …………………………….**