Dr L Huseen Dr M Shaw Dr C Mbah
MICKLEOVER SURGERY

Tel: 01332 519160 www.mickleoversurgery.co.uk

Thank you for applying to register as a patient of Mickleover Surgery. We would like to gather some information about you and request that you fill in the following questionnaire. You don't have to supply answers to all of the questions however, the information you enter on this form will help us to provide you with the best possible care.

Please complete all areas in **CAPITAL LETTERS** and tick the appropriate boxes.
Fields marked with a * are mandatory.

*Title *Surname	*First names
*Any previous surname(s)	*Date of Birth
*Male ☐ Female ☐	*NHS No. ☐☐☐☐☐☐☐☐☐☐
Town and country of birth	*Home address
*Home telephone No.	
Work Telephone No.	*Postcode
*Mobile telephone No. (If you have one)	Email address The practice may on occasion send information to patients by email. **Do you consent to receive emails from the practice?**

Additional details about you

Which of the following best describes your ethnic background					
White	☐ British	☐ Irish			
Black	☐ Caribbean	☐ African			
Asian	☐ Indian	☐ Pakistani	☐ Chinese		
Mixed	☐ White + Black Caribbean	☐ White + African	☐ White + Asian		
Other	☐ Please specify:				

Height	ft	in
Weight	st	lb
Waist measurement	in	

*Do you consent to the shared NHS Summary Care Record (SCR)? Yes No (please circle) **Further information about the Summary Care Record and what it means to you can be found by visiting:**
www.nhscarerecords.nhs.uk

If you tick YES but subsequently decide you do not wish to have a Summary Care Record you will need to request an opt out form.

(for female patients only) Have you had a cervical smear?

Yes No (please circle)

*Would you like to receive appointment reminders and test result notifications by text message? **I understand that by consenting to use this service I have a responsibility to inform the practice of any change to my mobile telephone number.**

Yes No (please circle)

Do you have a Carer? Yes / No
If yes, what is their name and contact number?
Do you consent for your carer to be informed about your medical care? Yes / No

Are you a Carer? Yes / No
If yes, do you look after someone who is a patient of Mickleover Surgery? Yes No Don't know (please circle)
If yes, what is their name?
Are they a: Relative ☐ Friend ☐ Neighbour ☐

Next of kin

Name of next of kin	Relationship to you
Next of kin telephone number(s)	Next of kin address (if different to above)

Patient Access

If you would like to register for online services which are accessed via the Patient Access system please ask the receptionist for a registration form and password. The Patient Access system enables patients to book and cancel appointments, order medication and access their Summary Care Record, should they wish to do so. Proof of identity is required in order to register for this service.

Medical details

If you are taking repeat medications it will be necessary for you to make an appointment with the GP to obtain your first repeat prescription from the practice. Please provide a print-out of your current medication.

*Are you allergic to any medicines? Yes / No (if yes please specify)

*List other allergies (pollen, animal hair or certain foods. Please mark "none" if you have no other allergies that you know of)

Have you ever had any of the following conditions?

	Yes/No	Year		Yes/No	Year
Epilepsy			Rheumatoid Arthritis		
High Blood Pressure			Mental Illness		
Heart Attack			Diabetes (type 1 or type 2)		
Angina (stable / unstable)			Asthma		
Stroke			COPD (or Emphysema)		
Transient Ischaemic Attack			Osteoporosis / Bone Fractures		
Cancer			Peripheral Vascular Disease		

List any serious illnesses / operations / accidents / disabilities (women: any pregnancy related problems) & the year they took place

Do you have family history of any of the following?

	Yes/No	Relationship
High Blood Pressure		
Ischaemic Heart Disease Diagnosed aged >60 yrs		
Ischaemic Heart Disease Diagnosed aged <60 yrs		
Raised Cholesterol		
Stroke / CVA		
Asthma		

	Yes/No	Relationship
DVT / Pulmonary Embolism		
Breast Cancer		
Any Cancer Specify type:		
Thyroid disorder		
Epilepsy		
Osteoporosis		

Please tell us about your smoking habits

Do you smoke? Yes / No

If yes, what do you primarily smoke:
Cigarettes / Cigar / Pipe (please circle)

How many do you smoke a day?
Would you like advice on quitting? Yes / No

Are you an ex-smoker? Yes / No
When did you quit?

How many did you smoke a day?

Please tell us about your alcohol consumption

Questions (please circle your answers)	**Unit scoring system**				
	0	**1**	**2**	**3**	**4**
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-4 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	7-9	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

Depending on your answers above you may be asked to complete an additional alcohol questionnaire.

1 UNIT	1.5 UNIT	2 UNITS		3 UNITS	9 UNITS	30 UNITS
 Normal beer half pint (284ml) 4%	 Small glass of wine(125ml) 12.5%	 Strong beer half pint (284ml) 6.5%	 Medium glass of wine (175ml) 12.5%	 Strong beer large bottle/can (440ml) 6.5%	 Bottle of wine (750ml) 12.5%	 Bottle of spirits (750ml) 40%
 Single spirit shot (25ml) 40%	 Alcopops bottle (275ml) 5.5%	 Normal beer large bottle/can (440ml) 4.5%		 Large glass of wine (250ml) 12.5%		

Do you have any information or communication support needs relating to a disability, impairment or sensory loss?
Yes **No** (please circle)

If Yes please indicate your communication support needs from the list below:

Easy Read ☐ Large Print ☐ BSL ☐ Braille ☐ Email or SMS text ☐ Other communication support ☐

Please record any additional information about you that you think is important for us to know

***Signed**

***Date**

Signed on behalf of patient (if applicable)
(e.g. minors under 16 years old, adults lacking capacity)