Oldwood Surgery
& Battle Health Centre

You will be registered with Dr   This will be your "Named GP"
Please take the time to fill in this questionnaire (print clearly)

About You:

Forename(s):		Title (Mr/Mrs/etc):	
Surname:		Date of Birth:	
Address:		Town, County & Country of Birth:	
Post Code:		NHS Number:	
Tel/Mob Number/s:		Occupation:	
Marital Status:	Single/Married/Widowed/ Co-Habiting	Name of Spouse or Partner:	
Your Ethnic Origin:		Your First Language:	
Email Address:			

Do you have any Communication Needs?		
No – [ ] Tick box & go to next section **Yes** - [ ] please give details	Do you have support? (i.e. advocate/note taker/sign language)	Do you need specific format? (i.e. large print/easyread/braille)
	Preferred contact method? (i.e. text, email, letter)	Do you need support? i.e. advocate/note taker/interpreter
Mobility	Fully mobile [ ] Housebound [ ] Mobile with aid [ ] (i.e. wheelchair, frame/sticks/assistance)	

Next of Kin:

Spouse or relative:		**Other contact in emergency:**	
Full Name:		Full Name:	
Address:		Address:	
Relationship to you:		Relationship to you:	
Contact No.:		Contact No.:	

Carer Details:

Are you a Carer/Young Carer? / Do you have a Carer? If you are a carer would you like to be added to the Practice's register to receive regular information and support?				
Yes ☐	No ☐			
(If yes) I care for (name):				
Relationship to you:				
The person I care for has:	Dementia ☐	Physical Disability ☐	Mental Illness ☐	Chronic Disease ☐

We offer a **New Patient Health Check** for every patient we take on. ***<u>Please make sure you have a date for yours</u> and PLEASE BRING A URINE SAMPLE*** on the day.	Date of check: ………………………………

Health Information:

Height	Weight	Waist measurement	Blood Pressure

Smoking Status	Never Smoked [ ] Ex-Smoker [ ] (when did you stop) …………….…… Current Smoker [ ] How many cigarettes per day on average …………….					
Alcohol	**Scoring System**					
	Questions	**0**	**1**	**2**	**3**	**4**	**Score**
	How often do you have a drink?	Never	Monthly or Less	2-4 times per month	2-3 times per week	4+ per week	
	How many units do you have a day?	1-2	3-4	5-6	7-8	10+	
	How often do you have 6+ units on an occasion?	Never	Less than Monthly	Monthly	Weekly	Daily/almost daily	
	1 unit is half pint of beer, 1 glass of wine or a pub measure of spirits					**Total:**	
Diet	Are you on any special diet (i.e. weight loss, gluten free, vegan) ……………………..						

Date of last flu vaccination:		**Date of last pneumonia vaccination:**	

Do **YOU** suffer from/ have you suffered from any of the following:	If yes, Date or Year	Do **YOU** suffer from/ have you suffered from any of the following:	If yes, Date or Year
Heart Attack		Liver disease or splenectomy	
Angina		Kidney Disease	
High Blood Pressure		Chronic lung Disease	
Coronary Artery Operations		Asthma	
Stroke/ CVA/ TIA		Osteoporosis	
DVT or pulmonary embolism		Psychiatric or Emotional Problem	
Thyroid Disease		Other Operations or Accidents	
Diabetes – controlled by diet Diabetes – controlled by insulin Diabetes – controlled by tablets		Cancer - Please give details;	
Do you have any drug /non-drug allergies?		Do you suffer from any other medical condition?	

Has any **family** member had / developed:	If yes - Who	Cancer (especially of breast, ovary or bowel)	
heart disease before the age of 60			
heart disease later than 60		Been diabetic	
Had strokes		Had or got asthma	

Cervical Smear Record (Women over 16 only)			
When do you think your last smear was		Do you use any form of contraception	Yes / No
Have you had a hysterectomy?		If yes – which one	
How many children have you had?		If a coil when was it fitted?	

Repeat Medications:
Please list below all repeat medications prescribed to you

Name of Medicine	Strength	Dosage	Name of Medicine	Strength	Dosage

You will need to see a Doctor the first time you require a repeat of your medication. Please make an appointment to do this, bringing your order slip or current medication with you. Once you have seen your Doctor you will then be able to order your repeat medication on a monthly basis.

Prescriptions: If you live more than one mile from your nearest pharmacy, you can collect your medication from our dispensary at either surgery. Alternatively you can nominate a pharmacy.	Dispensary – collect Oldwood Surgery [ ] Dispensary – collect Battle Health Centre [ ] Or: Nominated pharmacy: ....

Summary Care Record: We recommend you have additional clinical information on your NHS Summary Care Record so hospitals can access your medication and allergies. Find out more and how to opt out at: https://digital.nhs.uk/summary-care-records.	I want additional information on my NHS summary care record Yes [ ] No [ ]

Registration Documentation:

We have to see one of the following documents from part 1 and 2 in order to complete your registration. If you do not have these, please speak to a receptionist.

1. Proof of Identity - *Please circle which one you are providing*
UK Nationals: Photo Driving Licence, Birth Certificate, Marriage Certificate, Medical Card, Passport, N.I. Number, Photo Card, Evidence of Benefit entitlement
European Economic Area: Passport, European Health Card (EHIC not E111)
Non UK Nationals: ***Date Entered Country:*** Visa, Residence Permit, Work Permit, Student Visa or letter from educational establishment

2. Proof of Address – *Please circle which one you are providing*
Local Authority Rent Card, Paid Utility Bill (Gas/Electric/Phone including mobile), Bank Statement, Council Tax Documents

General Data Protection Regulation (GDPR): Consent

I hereby give my consent for Oldwood Surgery & Battle Health Centre to communicate with me by telephone, text and email.

I hereby give my consent for Oldwood Surgery & Battle Health Centre to communicate with me about non-medical matters e.g. text reminders for appointments, newsletters etc. Please note that you can choose to opt-out of this consent at any time.

Signed__________________________________ **Date:**__________________________________

For office use only: Please tick relevant box:

I.D provided:	
Proof of address provided:	
Data Protection Consent signed:	

Signature of staff member: **Date:**