***![MCj03616020000[1]]()Topsham Surgery***

**Application to register an NHS Patient with Topsham Surgery**

**Please use BLOCK CAPITALS and ensure all boxes are completed.**

|  |  |  |
| --- | --- | --- |
| Mr Mrs Miss Ms other  | Surname: |  |
| Date of Birth: |  | First names: |  |
| NHS No: |  | Previous name/s: |  |
| Male / Female |  | Town and country of birth: |  |
| Home Address: |  |
| Postcode: |  |
| Mobile Telephone number:  |  | Home phone no: |  |
| Email address: |  | Work phone no**:** |  |
| Text Messaging/Email Consent | By providing a mobile number you express consent for Topsham Surgery to send the number SMS messages. By providing an email address you express consent for Topsham Surgery to use this to contact you. |
| Preferred Method of Communicating | No Preference/ Text Message/ Email/Telephone/Letter |

|  |  |
| --- | --- |
| Do you have any specific communication needs? E.G. Hearing Loss / Visual Impairment | If yes, please state below how you would like us to communicate with you and explain what communication support would be helpful for you. |

**NEXT OF KIN**

|  |  |
| --- | --- |
| Pleaseprovide name and contact detailsof the person we should contact in the case of an emergency.Your medical details will not be shared with this person unless you give permission |  |
| What relationship is this person to you? |  |

**PLEASE HELP US TRACE YOUR PREVIOUS MEDICAL RECORDS BY PROVIDING THE FOLLOWING INFORMATION**

|  |  |
| --- | --- |
| Your Previous address in the UK: |  |
| Name & Address of Previous GP |  |

**IF YOU ARE FROM ABROAD**

|  |  |
| --- | --- |
| Your first UK address where registered with a GP: |  |
| Date you first came to live in the UK: |  | If a previous resident in the UK – Date of Leaving: |  |

**WERE YOU REGISTERED WITH AN ARMED FORCES GP?**

|  |  |
| --- | --- |
| Please indicate if you have served in the UK Armed Forces and/or been registered with a Ministry of Defence GP in the UK or overseas. | Please indicate whether :-Regular/Reservist/Veteran/Family Member |
| Address before Enlisting : |  |
| Service or Personnel Number:Enlistment Date :Discharge Date (if applicable) : |  |

*These questions are optional and your answers will not affect your entitlement to register or receive services from the NHS but may improve access to some NHS priority and service charities service.*

**YOUR ETHNICITY AND LANGUAGE**

NHS organisations are required to collect details ethnic origin together with native or first language. This information is collected to fulfil that obligation and is used for monitoring purposes only.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| WHITE: British or Mixed British |  | MIXED: White and Black African |  | ASIAN: Pakistani or British Pakistani |  | BLACK: African |  |
| WHITE: Irish |  | MIXED: White and Asian |  | ASIAN:Bangladeshi or British Bangladeshi |  |  BLACK: Any other background |  |
| WHITE:Any other background |  | MIXED: Any other background |  | ASIAN:Any other background |  |  CHINESE: |  |
| MIXED: White and Black Caribbean |  | ASIAN: Indian or British Indian |  | BLACK:Caribbean |  |  ANY OTHER ethnic group ………………………………… |  |
| I prefer not to specify my ethnic group. |  |  |
| **What is your first spoken language?** We will record your first spoken language as ENGLISH unless you specify otherwise. |  |

**ARE YOU A CARER?**

A Carer is someone of any age who provides unpaid support to family or friends who could not manage without this help.

**If YES, please complete this section.**

**IF YOU ARE BEING CARED FOR, please complete this section.**

|  |
| --- |
| **Details of the person(s) you are caring for** |
| Full Name |  |
| DOB |  |
| Address including Post Code |  |
| Telephone No. |  |
| Relationship to you |  |
| Is the person you care for registered at Topsham Surgery? | YES/NO |
|  |

|  |
| --- |
| **Details of your carer** |
| Full Name: |  |
| DOB |  |
| Address including Post Code  |  |
| Telephone No. |  |
| Relationship to you |  |
| Is the person you care for you registered at Topsham Surgery? | YES/NO |

If you consent to your Carer being informed of any medical information about you, which is held by the Surgery, please sign and date below; if NOT leave blank

**Signed: ……………………………………………………………….. Date: ……………………………**

**MEDICAL HISTORY**

**YOUR FAMILY HEALTH HISTORY**

Have your parents, brother(s) or sister(s) suffered from any of the problems listed below. Please tick and then **circle which family member** .

|  |  |  |
| --- | --- | --- |
| Diabetes  |  | Father / Mother / Sister / Brother |
| Asthma  |  | Father / Mother / Sister / Brother |
| High Blood Pressure  |  | Father / Mother / Sister / Brother |
| Stroke  |  | Father / Mother / Sister / Brother |
| Heart Disease  |  | Father / Mother / Sister / Brother |

**YOUR OWN HEALTH**

HEALTH PROBLEMS: Please **tick if you have a history of any of the following** health problems……

|  |  |
| --- | --- |
| **Please give an estimated year of diagnosis if you have any of the following:**  |  |
| **Cancer** |  | **Coronary Heart Disease, Heart Failure, or Atrial Fibrillation**  |  |
| **Dementia or Alzheimer’s** |  | **Depression or Mental Health problems**  |  |
| **Hypertension (High Blood Pressure)** |  | **Kidney Disease**  |  |
| **Asthma**  |  | **Stroke or Transient Ischemic Attacks**  |  |
| **COPD** |  | **Learning Difficulties** |  |
| **Diabetes**  |  | **Thyroid Disease** |  |
| **Epilepsy** |  |  |  |
| **If you have any other history or important illnesses or disabilities not mentioned above please give details here:** |
| **Are you awaiting any Hospital treatment? If yes please state.**  |  |

|  |  |
| --- | --- |
| **ALLERGIES:** Please list any allergies you have: |  |

|  |
| --- |
| **MEDICATION**:are you taking any regular / repeat medication? If so please make a list below OR attach the most recent repeat prescription list from your previous GP surgery. This information is essential to enable your new GP to authorise future repeat medication. |
|  |
| **PHARMACY :** The Practice uses Electronic Prescribing, please state which Pharmacy you would like your prescription sent to. |
| Topsham PharmacyTesco Pharmacy (please state which store) Any other Pharmacy (please state) | Glasshouse PharmacyBoots Pharmacy (please state which store) |
| **LIFESTYLE****ALCOHOL CONSUMPTION**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| How often do you have a drink containing alcohol?  | Never(0) | Monthly or Less(1) | 2-4 times a Month (2) | 2-3 times a Week(3) | 4 or more times a week(4) |
| How many units of alcohol do you drink on a typical day when you are drinking? | 1-2(0) | 3-4(1) | 5-6(2) | 7-9(3) | 10 or more(4) |
| 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(0) | Less than Monthly (1) | Monthly(2) | Weekly(3) | Daily or almost daily(4) |
| TOTAL SCORE |

**YOUR SMOKING STATUS** (Please tick boxes and complete with information as appropriate)

|  |  |  |  |
| --- | --- | --- | --- |
| Never Smoked |  | N/A |  |
| Ex- Smoker |  | Date Stopped? |  |
| Cigarette Smoker |  | How many per day? |  |
| Roll Own Cigarettes |  | How many per day? |  |
| Cigar Smoker  |  | How many per day? |  |
| Pipe Smoker  |  | How many ounces per week? |  |

**EXERCISE**

|  |
| --- |
| EXERCISE: Please **circle** which of these terms best describes how much exercise you take on a regular basis. |
| None |  Light | Moderate |  Heavy |
| Body Measurements | Height | Weight | Waist Circumference  |
|  |  |  |
| BP |  |  |  |

**FOR FEMALES AGED 15 – 65**

|  |
| --- |
| **If you use any form of contraception please circle which one.** |
| Coil | Depot injection | Implant | Oral Pill | Patches | Other…………………………………. |
| If you do use contraception, when was your last check-up / review with GP or Nurse? | Date: |
| If you have a Coil or Implant approximately what date was it fitted? | Date: |
| If you have depot injections when was your last one? | Date: |
| Have you had a recent smear? | Date: |
| Have you had a recent mammogram? | Date : |

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**CHANGE OF DETAILS**

|  |
| --- |
| I understand that it is my responsibility to inform Topsham Surgery should my phone number, email or any other personal details change. |

|  |  |
| --- | --- |
| **SIGNATURE OF PATIENT :** |  |
| **OR SIGNATURE on behalf of a patient:** |  |
| **DATE:** |  |

|  |
| --- |
| **Office use only** |
| **Proof of residency /ID checked by……………………………………………… Date ………………….**  |
| □ Passport  | □ Birth Certificate |
| □ Driving Licence  | □ Proof of Address / Utility Bill |
| □ Work / Study Permit  | □ Update Nominated Pharmacy |
| □ Donor Form Signed  | **Signature of member of staff****Allocated GP (XacWQ)****Patient Informed of named GP (Xab9D)** |

**Form dated October 2020**