Thank you for applying to join Brownsover Medical Centre. We would like to gather some information about you and ask that you fill in the following questionnaire. You don't have to supply answers to all of the questions but what you do fill in will help us give you the best possible care. **Please supply two forms of Identification with your completed form, a photographic form of ID (such as passport or driving license) and proof of your home address (such as a recent bank statement or document relating to your new home).**

Please complete all areas in **CAPITAL LETTERS** and tick the appropriate boxes.
Fields marked with an asterix (*) are mandatory.

*Title *Surname	*First names
*Any previous surname(s)	*Date of Birth
*☐Male ☐Female ☐Intermediate ☐Unspecified	*NHS No. ☐☐☐☐☐☐☐☐☐☐
Town and country of birth	*Home address & Postcode *Previous address & Postcode
Home telephone No. Preferred Number ☐Yes ☐No	
Work telephone No. Preferred Number ☐Yes ☐No	
Mobile No. Preferred Number ☐Yes ☐No	Email address

*Previous GP Details	If you are from abroad please tell us your first UK address where registered with a GP: If previously resident in UK, date of leaving: Date you first came to live in UK:
(**for women only**) Have you had a cervical smear? ☐Yes ☐No (*Please state where, when and the result if possible*)	Marital Status? ☐Single ☐Married ☐Divorced ☐Widowed

Additional details about you

What is your ethnic group?						
White	☐	British	☐	Irish		
Black	☐	Caribbean	☐	African		
Asian	☐	Indian	☐	Pakistani	☐	Chinese
Mixed	☐	White + Black Caribbean	☐	White + African	☐	White + Asian
Other	☐	*Please specify*:				

Main Language Spoken?
(E.g. English)

Have you ever been in the employ of the Armed Forces? ☐ Yes ☐ No
Personnel Number: ***Date Enlisted:*** ***Date Left:***

Are you a dependant of a current serving member of British Armed Forces? ☐ Yes ☐ No

Next of kin \ Emergency contact

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

Data Sharing

Summary Care Record (SCR)
Your SCR is an electronic summary of key medical information taken from your GP medical record. If you need healthcare away from your usual doctor's surgery, your enhanced SCR will provide those looking after you with key information to help them give you better and quicker care. Please refer to **'What is a Summary Care Record'** document for more information **or visit: https://digital.nhs.uk/summary-care-records/patients**
Tick this box if you wish to have an enhanced SCR with core and additional information (recommended) ☐
Tick this box if you wish to opt-out of the SCR ☐

Medical Interoperability Gateway (MIG)
The MIG enables secure sharing of relevant medical information from your GP record with other healthcare professionals who are providing you with direct care, even if they are not using the same electronic records system. At point of care you will be asked if you consent to the care service seeing essential elements of your record.
More information can be found by visiting: http://www.healthcaregateway.co.uk/products

Tick this box if you wish to opt-out of the MIG data sharing ☐

Risk Stratification Preferences
Risk stratification is the process of identifying the relative **risk** of patients in a population by analysing their medical history. It's a key enabler for improving the quality of care delivered by the NHS. Brownsover Medical Centre is taking part in the Risk Stratification programme and will be uploading patient identifiable data for analysis. Patient identifiable information will only be viewable at GP practice level. Any NHS organisation external to the practice using risk stratification will only see anonymised data.
For more information please visit our website at www.brownsovermedicalcentre.nhs.uk

Tick this box if you wish to opt-out of the Risk Stratification programme ☐

Enhanced Data Sharing Module (EDSM)
Brownsover Medical Centre use a clinical computer system called EMIS to record your medical information. With your consent, you can allow your full GP record to be shared with other healthcare services that are providing care for you and who also use EMIS. These other services will always ask consent to view your record. **For more information please visit our website at www.brownsovermedicalcentre.nhs.uk**

Tick this box if you wish to opt-out of the Enhanced Data Sharing Module ☐

*Do you consent to receive the following types of communication (if offered) from Brownsover Medical Centre?

Email ☐Yes ☐No

Mobile phone text messages ☐Yes ☐No

Answering machine messages ☐Yes ☐No

Carers Information

A carer is a friend or family member who gives their time to support a person in their home, to an extent that the person could not remain at home if this care was not being provided. A carer can receive Carers Allowance, but not a wage and the care they are giving will significantly affect their own life.

Are you looked after by someone who's support you could not manage without? ☐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

Do you look after or support someone who couldn't manage without you? ☐Yes ☐No
If yes, do you look after someone who is a patient of Brownsover Medical Centre? ☐Yes ☐No ☐ Don't know
If yes, what is their name?
Are they a: ☐Relative ☐Friend ☐Neighbour

Medical details

In order to continue to receive your repeat medications you'll need to make a new patient health check appointment and bring in your last repeat prescription. (Please note, certain medications will require an appointment with the GP before they can be prescribed) Please allow plenty of time to organise repeats. Please provide us with your repeat medication list found on the right hand side or a printed prescription.

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

*List other allergies / intolerances (i.e. nuts, gluten, 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?

Epilepsy	☐ Yes	Year	**Mental Illness**	☐ Yes	Year
High Blood Pressure	☐ Yes	Year	**Diabetes**	☐ Yes	Year
Heart Attack / Angina	☐ Yes	Year	**Asthma**	☐ Yes	Year
Stroke / Mini-stroke (TIA)	☐ Yes	Year	**COPD (or Emphysema)**	☐ Yes	Year
Cancer	☐ Yes	Year	**Osteoporosis / Bone fractures**	☐ Yes	Year
Rheumatoid Arthritis	☐ Yes	Year	**Peripheral vascular disease**	☐ Yes	Year

Do you have any disabilities, illnesses or accessibility needs? I.e. needing to be seen in ground floor consulting rooms or use of a specific communication device such as a hearing aid? If yes, please tell us how we can support your needs.

The Accessible Information Standard (AIS)
Please use this space to tell us about any specific communication needs you have. I.e. needing information in large print or deafblind telephone contact. For further information please visit **https://www.england.nhs.uk/ourwork/accessibleinfo/**

Do you have family history of any of the following?

High Blood Pressure	☐ Yes	Who	**DVT / Pulmonary Embolism**	☐ Yes	Who
Ischaemic Heart Disease Diagnosed aged >60 yrs	☐ Yes	Who	**Breast Cancer**	☐ Yes	Who
Ischaemic Heart Disease Diagnosed aged <60 yrs	☐ Yes	Who	**Any Cancer** Specify type:	☐ Yes	Who
Raised Cholesterol	☐ Yes	Who	**Thyroid disorder**	☐ Yes	Who
Stroke / CVA	☐ Yes	Who	**Epilepsy**	☐ Yes	Who
Asthma	☐ Yes	Who	**Osteoporosis**	☐ Yes	Who

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

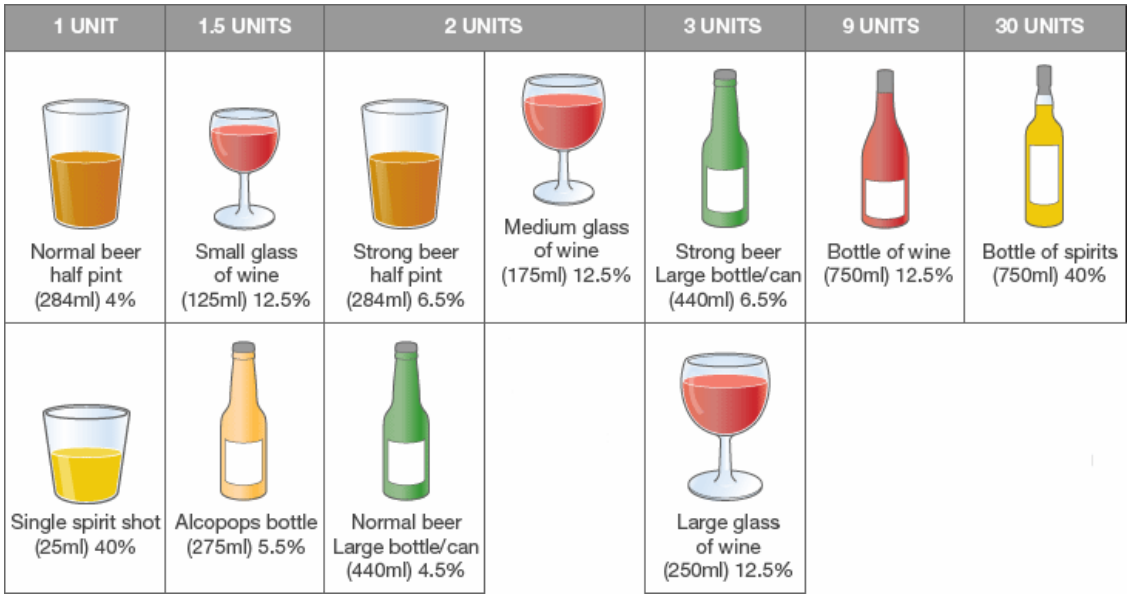
Are you an ex-smoker ☐ Yes ☐ No
When did you quit?

How many did you used to 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.



Do you exercise regularly? ☐ Yes ☐ No

If so – What exercise do you take?

How often?

*In accordance with the Data Protection Act, the practice needs consent if you are happy for a 3rd party to collect prescriptions, test results and other medical information on your behalf. Please complete this section if you would like to register a 3rd party.

I give consent for _____ to collect prescriptions on my behalf (Please note that we are unable to hand out prescriptions to anyone under the age of 15)

I give consent for _____ to obtain test results / medical information / appointment information on my behalf (Delete as appropriate)

IT IS YOUR RESPONSIBILITY TO ADVISE US OF ANY CHANGES TO THESE INSTRUCTIONS:

Signed: _____ Date: _____

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

Electronic Prescription Service (EPS)
EPS enables prescribers - such as GPs and practice nurses - to send prescriptions electronically to a dispenser (such as a pharmacy) of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff.
If you have already nominated a pharmacy, please tell us which pharmacy you have chosen. For further information about this service, please talk to your pharmacist of choice.

Patient Participation Group (PPG).
For more information please get in contact with a member of our reception team.

NHS Organ Donor registration
I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.

☐ Any of my organs and tissue or
☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

For more information, please visit the website *www.uktransplant.org.uk* or call 0300 123 23 23

***Signed**

***Date / / /**

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

Once you are registered…

If there are any problems with your registration we'll contact you to clarify any issues, but once your details have been entered into our computerized records…

On-line Services

…You will be able to register with our on-line service and access appointments, prescriptions and some sections of your own medical record via the internet. All of the details that you need for this are available by requesting to be registered at reception.

New Patient Health-check

…You will be eligible for a new patient health-check with a Practice Nurse/Health Care Assistant. Contact reception if you should like to take this up.

FOR OFFICE USE ONLY

PHOTO ID ☐ **TYPE:** _____
(Over 18 only)

ADDRESS ID ☐ **TYPE:** _____