Bishops Waltham Surgery
Phone: 01489 892288 / Email: whccg.bwsurgery@nhs

New Patient Registration

About you

Surname: …… Forename(s): ……

Date of Birth (dd/mm/yyyy): ……..

Gender: ……

Contact Information

Address:…….

Telephone: …… Mobile: ……

Email: ……

Please circle below your preferred choice of contact:

Text **Phone (mobile)** **Phone (Home)** **Email** **Post**

Do you live in a residential/nursing home? **Yes** ☐ **No** ☐

Are you housebound? ……..

What is your occupation?.....

Service Families and Military Veterans

As a practice, we fully support the Armed Forces Covenant. We can only do this if we know our patients connections to the Armed Forces. Please tick the below boxes that apply to you:

I AM a Military Veteran		**I AM** currently serving in the Reserve Forces	
I AM married/civil partnership to a serving member of the Regular/Reserve Armed Forces		**I AM** married/civil partnership to a Military Veteran	
I AM under 18 and my parent(s) are serving member(s) of the armed forces.		**I AM** under 18 and my parent(s) are veteran(s) of the armed forces.	

Ethnicity

Having information about patients' ethnic groups would be helpful for the NHS so that it can plan and provide culturally appropriate and better services to meet patients' needs.

If you do not wish to provide this information you do not have to do so.

Please indicate your ethnic origin by ticking the below box:

British or mixed British		Pakistani	
Irish		Bangladeshi	
African		Chinese	
Caribbean		Other (Please state)	
Indian			

Country of birth

In which country were you born?.....

Main language

Which is your main language?.....

Do you need an interpreter?.....

Preferred title

How would you like us to refer to you (eg Mr, Mrs, Miss, Mx)?.....

Preferred title for official correspondence?.....

Carer status

Do you have a carer? **Yes** ☐ **No** ☐

If Yes, please give details of their name, relationship and whether they are a patient here too……..

Are you yourself a carer? **Yes** ☐ **No** ☐

Next of kin

Surname: …… Forename(s): ……

Gender: ……

Emergency contact Information (for next of kin)

Telephone: …… Mobile: ……

Contacting you

We will use your contact details to send reminders about appointments, reviews and other services which may be of benefit in your medical care

Do you consent to the Surgery sending text messages to your mobile? **Yes** ☐ **No** ☐

Do you consent to the Surgery sending messages to you by email? **Yes** ☐ **No** ☐

Do you consent to the Surgery sending letters to your home address? **Yes** ☐ **No** ☐

Do you consent to the Surgery leaving messages on your phone? **Yes** ☐ **No** ☐

(We will not leave detailed messages on your phone, but may ask you to contact us or leave a simple message if we do not need to speak to you).

Do you have a preferred method of contact? ……..

Are you interested in joining our Patient Participation Group (PPG)? **Yes** ☐ **No** ☐

Summary Care Record (SCR)

If you decide to have a SCR, it will contain important information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines that you have had it will also include basic information about your current diagnoses. Giving healthcare staff access to this information can prevent mistakes being made when caring for you in an emergency or when your GP practice is closed. Your Summary Care Record will also include your name, address, date of birth and your unique NHS Number to help identify you correctly. If you and your GP decide to include more information it can be added, but only with your express permission. **For more information**: Phone 0300 123 3020 or visit www.nhscarerecords.nhs.uk

I do not wish to have a Summary care Record **I wish to opt out of SCR** ☐
(N.B. this will mean NHS Healthcare staff caring for you may not be aware of your current medications, any allergies or reactions to previous medication.)

Electronic Prescribing Service (EPS)

The EPS allows 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. The NHS aim that by 2020 they will hopefully be paper free or a paper-lite service. To help achieve this, we would encourage all patients to opt for electronic prescribing.

☐ **I DO** give consent for my prescriptions to be sent electronically to the pharmacy

☐ **I DO NOT** give consent for my prescriptions to be sent electronically to the pharmacy

Nominated pharmacy……

Address……

Postcode……

Dispensing Patients only

☐ I live more than 1 mile (1.6km) "as the crow flies", from the nearest chemist / pharmacy and would therefore like the surgery to dispense my medicines and appliances

☐ I am housebound/disabled/elderly and cannot get to a pharmacy easily and would like to register for the home delivery service

If you are unable to be a dispensing patient please nominate a pharmacy for your prescriptions to be sent to.

Donation wishes

If you live in England, Wales or Jersey, are not in a group excluded from opt out legislation and you have not registered an organ donation decision, it will be considered that you agree to be an organ donor. This is known as deemed consent.
If you do not want to donate your organs then you should register your decision to refuse to donate. Remember to speak to your family and loved ones about your decision. To opt out, visit:
https://ardens.live/Organ-donation-opt-out

Do you have a donor card or are you on the organ donation register?	**Yes**	☐	**No**	☐
Have you opted out?	**Yes**	☐	**No**	☐
Do you donate blood?	**Yes**	☐	**N**	☐

Resuscitation wishes and Power of Attorney

Do you have a DNACPR (Do not attempt CPR) form in place?	**Yes**	☐	**No**	☐
Does anybody hold Lasting Power of Attorney for Health and Welfare for you?	**Yes**	☐	**No**	☐

If **YES to either of the above questions**, please supply details of who holds this and where (and supply a copy for your medical notes).
Details……

Lifestyle - Smoking status

Do you smoke? **Yes** ☐ **No** ☐

If yes, how many cigarettes do you smoke daily: ……

If no, have you smoked in the past? **Yes** ☐ **No** ☐

Do you use electronic cigarettes/vape? **Yes** ☐ **No** ☐

Would you like help to stop smoking? **Yes** ☐ **No** ☐

Smoking is the UK's single greatest cause of preventable illness
Stopping smoking is not easy but it can be done, and there is now a comprehensive, NHS Smoking Cessation Service offering support and help to smokers wanting to stop, with cessation aids available on NHS prescription.

If you would like help and advice on how to give up smoking, please contact https://www.quit4life.nhs.uk/ or ask at reception.

Height/Weight

What is your height: ……

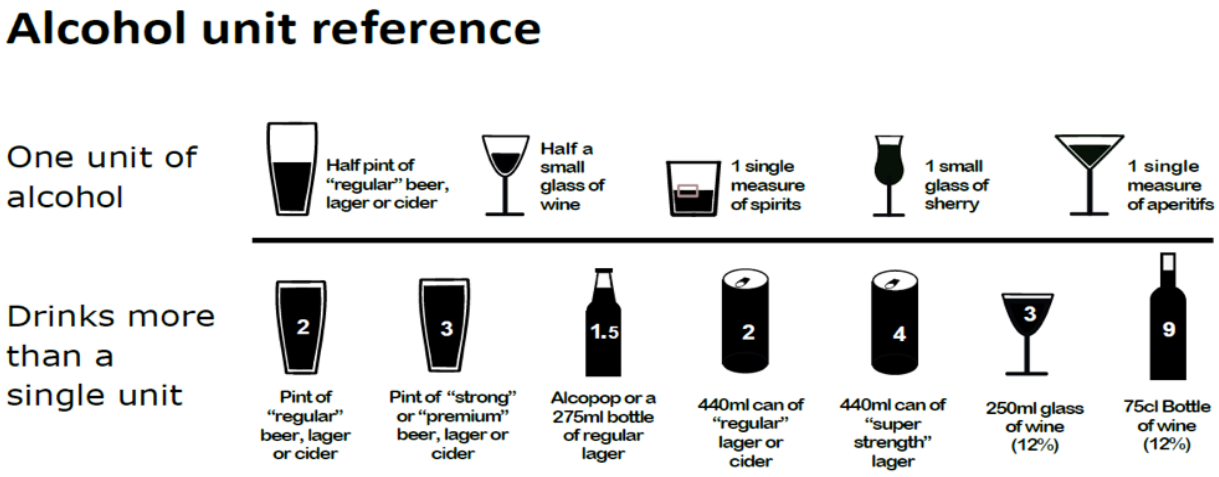
What is your weight:……..

Blood Pressure: …….

If you would like advice on managing a healthy weight, please contact https://www.nhs.uk/live-well/ or reception who will be able to direct you to the most appropriate service.

Alcohol intake

Alcohol consumption:……
(Please use the table below to work out how many units you drink per week)



Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink	Never	Monthly or	2-4 times	2-3 times per	4+ times	

that contains alcohol?		less	per month	week	per week	
How many alcoholic drinks do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring
Score: …….

A total of 5+ indicates increasing or higher risk drinking. If you have a score of 5+ please complete the remaining questions below.

Questions	Scoring system					Your score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Questions	**Scoring system**					**Your score**
	0	**1**	**2**	**3**	**4**	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Please add up your scores from the above tables and write the total below:
Total……..

If you would like help and advice on how to reduce your alcohol intake, please contact https://www.drinkaware.co.uk/ or ask at reception.

Exercise

General Practice Physical Activity Questionnaire

1. Please tell us the type and amount of physical activity involved in your work.

		Please mark one box only
a	I am not in employment (e.g. retired, retired for health reasons, unemployed, fulltime carer etc.)	
b	I spend most of my time at work sitting (such as in an office)	
c	I spend most of my time at work standing or walking. However, my work does not require much intense physical effort (e.g. shop assistant, hairdresser, security guard, childminder, etc.)	
d	My work involves definite physical effort including handling of heavy objects and use of tools (e.g. plumber, electrician, carpenter, cleaner, hospital nurse, gardener, postal delivery workers etc.)	
e	My work involves vigorous physical activity including handling of very heavy objects (e.g. scaffolder, construction worker, refuse collector, etc.)	

2. During the *last week*, how many hours did you spend on each of the following activities? *Please answer whether you are in employment or not*

Please mark one box only on each row

		None	**Some but less than 1 hour**	**1 hour but less than 3 hours**	**3 hours or more**
a	Physical exercise such as swimming, jogging, aerobics, football, tennis, gym workout etc.				
b	Cycling, including cycling to work and during leisure time				
c	Walking, including walking to work, shopping, for pleasure etc.				
d	Housework/Childcare				
e	Gardening/DIY				

3. How would you describe your usual walking pace? Please mark one box only.

Slow pace (i.e. less than 3 mph)		Steady average pace	
Brisk pace		Fast pace (i.e. over 4mph)	

Disabilities / Accessible Information Standards

As a practice we want to make sure that we give you information that is clear to you. For that reason we would like to know if you have any communication needs.

Are you blind/partially sighted? **Yes** ☐ **No** ☐

Do you have significant problems with your hearing? **Yes** ☐ **No** ☐

Are you dependent on a wheelchair? **Yes** ☐ **No** ☐

Do you have any problems with your speech? **Yes** ☐ **No** ☐

Do you have any other disabilities? If so please record the nature of the disability: ……..

Family History

Have any close relatives (parent, sibling or child only) ever suffered from any of the following?

Condition	Yes	No
Heart Disease (Heart attack/Angina)		
Stroke		
Diabetes		
Asthma		
Cancer		
Hypertension		
Rheumatoid Arthritis		
Epilepsy		
Glaucoma		
Parkinson's Disease		

Personal Medical History

Have you yourself ever suffered from any important medical illness, operation or admission to hospital? **If so** please enter details below:

Condition	**Year diagnosed**	**Ongoing?**

Immunisations

Immunisation	Year	Immunisation	Year	Immunisation
1st Infanrix Hexa DTP, IPV HIB, HEPB		1st Pneumonia (Prevenar)		
2nd		2nd Pneumonia		
3rd		Menintorix (HIB/MEN C)		
1st Rotarix		1st MMR		
2nd		2nd MMR		
1st Meningitis B		DTP + IPV (Preschool)		
2nd		DTP (Aged 14)		
3rd		1st HPV		
		2nd		
		Men ACWY		

Allergies

Please list any drug or food allergies that you have:
……
……
……

Medications

Please provide a list of repeat medications:
……
……
……

For female patients only

Are you currently pregnant? **Yes** ☐ **No** ☐

If yes, *please ensure you are under the care of a midwife. If you're not currently under the care of a midwife please speak to reception regarding this.*

Which method of contraception (if any) are you using at present?
……

Do you currently have long acting reversible contraception in place? *(Implant/Coil)*

Yes ☐ **No** ☐

If yes, when was this fitted? (dd/mm/yy) **……**

Have you had a cervical smear test? **Yes** ☐ **No** ☐

If yes, when was this last done? (dd/mm/yy) **……**

Have you had a hysterectomy?	**Yes**	☐	**No**	☐
Do you still have your ovaries?	**Yes**	☐	**No**	☐

Signature

I confirm that the information I have provided is true to the best of my knowledge:

Signature: ……

Date: ……