



If you need any support in completing this form, please ask at the reception

Thank you for applying to join Broom Leys Surgery. 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) if you do not have photographic ID then please bring your birth certificate and proof of your home address (such as a recent bank statement or document relating to your new home with your name on).**

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

*Title	*First names
*Surname	
* <input type="checkbox"/> Male	<input type="checkbox"/> Female
*Date of Birth	
*Home telephone No.	
Work telephone No.	
*Mobile No. (if you have one)	

* Any previous surname(s)
Town and country of birth
*NHS No. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (if known)
*Home address
*Postcode
Email address

Previous address and doctors details

*Previous address in the UK
Postcode

Name of previous doctor while at previous address
Address of previous doctor

If you are from abroad

*Your first UK address where you registered with a GP
Postcode

*If previously a resident in the UK, date of leaving
*Date you first came to live in the UK if applicable

If you are returning from the Armed Forces

Address before enlisting
Postcode

Service or Personnel No.
Enlistment date

If you are applying on behalf of a child who is in foster care/residential care/Kinship care/ or who is not your child

Who has the legal responsibility for the child?
<input type="checkbox"/> You as the legal parent or guardian
<input type="checkbox"/> Other (please specify) _____

Who can consent for the medical treatment for the child?
<input type="checkbox"/> You as the legal parent or guardian
<input type="checkbox"/> Other (please specify) _____

Additional details about you

*What is your ethnic group? (Choose an option that best describe your ethnic group or background)

- | | | | | | | |
|--------------|--------------------------|-------------------------|--------------------------|-----------------|--------------------------|---------------|
| White | <input type="checkbox"/> | English/Welsh/Scottish | <input type="checkbox"/> | Northern Irish | <input type="checkbox"/> | Irish |
| Black | <input type="checkbox"/> | Caribbean | <input type="checkbox"/> | African | <input type="checkbox"/> | Other |
| Asian | <input type="checkbox"/> | Indian | <input type="checkbox"/> | Pakistani | <input type="checkbox"/> | Chinese |
| Mixed | <input type="checkbox"/> | White + Black Caribbean | <input type="checkbox"/> | White + African | <input type="checkbox"/> | White + Asian |
| Other | <input type="checkbox"/> | Please specify: | | | | |

*Main spoken languages

- English**
- Other** (please specify)

Interpreter required?

- Yes No

Data Sharing

Summary Care Record (SCR)

The SCR is a summary of your medical history that can be shared between healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information. **More information can be found by visiting www.nhscarecords.nhs.uk**

Tick this box if wish to **opt-out** of the SCR

*Do you consent to receive the following types of communication from Broom Leys Surgery?

- Email** Yes No
- Mobile phone text messages** Yes No
- Answering machine messages** Yes No

Medical Interoperability Gateway (MIG)

Whilst the SCR mentioned above shares a very small portion of your medical record across the whole NHS, the MIG shares a much fuller view of your records but only with local NHS providers – and only when you give explicit consent at the point of care.

For more information please visit our website at www.broomleysurgery.co.uk

Tick this box if you wish to **opt-out** of the MIG

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 Broom Leys Surgery? Yes No Don't know

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)

Medical details

In order to continue to receive your repeat medications you'll need to make an appointment with a GP at Broom Leys Surgery at least one week before your next prescription is due.

*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)

Looked after Children

Are you looking after someone else's child? Yes No

If Yes, under what arrangements:

- Section 20-Voluntary Care Interim Care Order Care Order
- Child arrangement order/Residence Order Special Guardianship order
- Placed for adoption
- Private arrangement/Private Fostering/informal arrangement
- (please note you have a duty to notify social care of this arrangement)

Please tell us about your smoking habits

Do you smoke? Yes No

If Yes, what do you primarily smoke:

- Pipe Cigarettes Cigar Other












How many do you smoke a day? _____

Would you like advice on quitting?

- Yes No

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 (go to Page 4)	Monthly or less	2 - 4 times Per month	2 - 4 times per	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
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 you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
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 you cut down?	No		Yes, but not in the last year		Yes, during the last year

1 UNIT	1.5 UNITS	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%			

Please provide information below if known

Height	ft	in
Weight	st	lb
Waist measurement	in	

(for women aged 25 to 64) Have you had a cervical smear test?

Yes No

If Yes Please state where, when and the result(if known)

Please record any additional information about you that you think is important for us to know
 (Additional information includes: Social worker involved with your family; legal parental responsibilities of minor under 16 years old; applicant is in foster care or is adopted; if you are from overseas and claiming asylum or are a refugee)

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 (dd/mm/yyyy) / /

Signed on behalf of patient (if applicable)
 (Minors under 16 years old, adults lacking capacity)

Full Name:

Relationship:

Online services

If there are any problems with your registration we will contact you to clarify any issues, but once your details have been entered into our computerised records you will be able to register with our **on-line service** provider (System One) 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 on our practice website at www.broomleysurgery.co.uk on the online services page.

Thank you for providing this information. We look forward to providing you with high standard of care in a friendly and professional manner.

Please take a copy of our practice leaflet.

FOR OFFICE USE ONLY

PHOTO ID/Birth Certificate (Over 18 only) TYPE: _____

ADDRESS ID TYPE: _____

Other TYPE: _____