Please complete the Health Questionnaire below and indicate which practice you would like to join. Information regarding the practice and the services they offer can be found in the Practice Booklet.

I am registering with:

Bank Street Medical Group ☐ Eden Villa Medical Practice ☐

We would like to collect some information about you and ask that you fill in the following questionnaire. This will enable us to give you the best possible care.

Please complete all areas in **CAPITAL LETTERS** and tick the appropriate boxes.

Title Surname	First names
Date of Birth	Contact telephone numbers
Consent to leave voicemail ☐ Yes ☐ No	Email address

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:*				

Carer information

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 this practice? ☐ 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)

Allergies

*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)

Medication

Please provide a copy of your repeat prescription from your previous surgery; this will enable us to issue a prescription for your repeat medication.

Please record any additional information, for example any serious illnesses or recent operations

Have you ever had any of the following conditions?

Epilepsy	☐ Yes	Year
High Blood Pressure	☐ Yes	Year
Heart Attack / Angina	☐ Yes	Year
Stroke / Mini-stroke (TIA)	☐ Yes	Year
Cancer	☐ Yes	Year
Rheumatoid Arthritis	☐ Yes	Year

Mental Illness	☐ Yes	Year
Diabetes	☐ Yes	Year
Asthma	☐ Yes	Year
COPD	☐ Yes	Year
Osteoporosis / Bone fractures	☐ Yes	Year
Peripheral vascular disease	☐ Yes	Year

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. = 1 small glass of wine, I measure of spirit, ½ pint beer or lager

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? See chart below	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
How often during the last year have you been unable to remember what happened the night before because you had been drinking alcohol?	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 of you because of drinking alcohol?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Has a relative or friend, a doctor or other health care worker been concerned about your drinking or suggested you cut down?	Never		Yes, but not in the last year		Yes, in the last year

Signature

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

<u>On-line Services – Patient Access. – Two weeks after registration</u>

You will be able to register for our on-line services for access which allows you to make/cancel appointments and order repeat prescriptions. Please ask one of our receptionists for further details.

<u>New Patient Health-check</u>

You will be eligible for a new patient health-check with a Practice Nurse if you wish to have one. Contact reception if you should like to make an appointment for a New Patient Health-check.