Wickham Surgery

Supplementary registration information & lifestyle questionnaire

To bring your records up to date immediately, please complete the additional information below and attached and return it with your GMS1 registration form. You will be asked to provide two forms of identification (1 photographic and 1 proof of address) so please bring these with you when returning to the practice.

All information provided is handled in strict confidence.

Would you like this document or any future correspondence or information in an alternative format, for example large print or easy read, or do you need help with communicating with us, for example because you use British Sign Language?

Yes ☐ No ☐

Thank you

Have you ever been registered with our practice before? YES/NO

First Name	Surname	Height (m or ft)
Tel:	Mobile:	Weight (kg or st/lbs)
Email:		
First spoken language:		
SMOKING		
Do you, or have you ever smoked? Never Smoked Previously smoked (how long ago ……..) Current smoker		
If you currently smoke, would you like details of the smoking cessation service Quit For Life? Yes please No thank you		
ALLERGIES Do you have any allergies? If so, please list: ……..		
EXERCISE Approximately how many hours of exercise do you undertake in one week? ……. What type of exercise do you undertake? ……..		
CARERS Are you a Carer? YES/NO Is the person you care for a: Relative YES/N NEIGHBOUR: YES/NO FRIEND: YES/NO Would you like any information concerning Carers? Yes please No thank you		
Mental Health History Do you currently or have you previously suffered from a mental health condition? Yes No		

Are you returning from the Armed Forces? YES/NO

If YES please complete the following:

Address before enlisting: Please state the address where you were last registered with a GP Practice before enlisting:	
Service or Personnel Number:	
Enlistment Date:	
Leaving Date:	

The Department of Health requests that we record the ethnic origin of our patients. For this purpose, which of the following ethnic groups do you consider you belong to? (Please circle).

White: White British White Irish Any other white background	*Black or Black British*: Caribbean African Any other Black background	*Mixed*: White & Black Caribbean White & Black African White and Asian Any other mixed background
Asian or Asian British: Indian Pakistani Bangladeshi Any other Asian background	*Other ethnic groups*: Chinese Any other ethnic group	I would prefer not to provide this information

Family Medical History

Please indicate if a close family member has suffered any of the following conditions:

CONDITION	***FAMILY MEMBER***
Ischaemic Heart Disease	
Stroke	
Diabetes Mellitus	
Asthma	
Breast Cancer	
Bowel Cancer	
Glaucoma	
Thyroid disorder	
High blood pressure	

☐ Are you interested in becoming a member of our **Patient Reference Group**? Please tick

Contacting you

We are constantly seeking new ways of improving both NHS services and, where appropriate, patient funded services that we offer our patients at Wickham Surgery.

☐ Please keep me informed of any changes to patient services at my GP surgery.

☐ There may be occasions when we will contact you by e-mail. If this is acceptable please tick and ensure you have entered your full contact details overleaf.

Text/Voice Text Messages

☐ The GP Practice will on occasion wish to send **SMS Text Messages** or **SMS Voice Message** to your mobile phone or fixed land line number in order to notify you of such circumstances as changes to your booked appointment, national issues such as Flu pandemics, the GP Practice being closed due to unforeseen circumstances etc. If you wish the GP Practice to contact you this manner then please tick.

Disclaimer

If you agree to the GP Practice contacting you via your mobile phone or fixed land line number, the GP Practice agrees to adhere to the following:-

1. The mobile phone number or fixed land line number will only be used by the GP Practice and will not be passed to any other parties.
2. If at any time you would like to opt out of either of the above services, please make a personal request to the GP Practice and you will be opted out of the service within 48 hours. You may also like to include your reason for opting out, to help us review and improve the service in future.
3. Your mobile phone number will solely be used by the GP Practice in relation to the healthcare services offered by the GP Practice. You will not be contacted in relation to any other types of products or services.

By ticking the boxes you are giving consent for us to contact you on the details overleaf

Signature:……

Name: ……

Name: ……

ALCOHOL CONSUMPTION (Audit C)

Alcohol is the 3rd most important health risk factor after smoking and raised blood pressure. It is a government priority to address the issue of illness associated with increasing alcohol consumption.

Please complete questions 1 to 3 and if your score at Total 1 is 5 or more, please continue with questions 4 to 10 and enter your overall total.

Question set 1	Scoring System					Your
	0	1	2	3	4	Score
1. How often do you have a drink that contains alcohol?	Never	Monthly or less	2 – 4 times Per month	2 – 3 times per week	4+ times per week	
2. How many standard alcoholic units do you have on a typical day when you are drinking?	1 – 2	3 - 4	5 - 6	7 - 9	10+	
3. How often do you have 6 or more standard units on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					Total 1.	
4. How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10.Has a relative/ friend/ doctor/ health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total 2	
					Total 1+2	

For surgery use	ID Seen	Receptionist's initials:	Registered by:
Photo ID (i.e. Passport, driving licence).	YES / NO		
Proof of residency (i.e. utility bill, bank statement)	YES / NO		