**Broadway Surgery New Patient Registration – Adult**

**Please complete all sections in FULL using BLOCK capital letters.**

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| **Your Details** |
| Title | Mr [ ]  Mrs [ ]  Miss [ ]  Ms [ ]  Other [ ]  |
| Surname |  |
| First Name(s) |  |
| Previous Surname (if applicable) |  |
| Date of Birth (dd/mm/yyy) |  | NHS Number |  |
| Gender | Male [ ]  Female [ ]   |
| Town & Country of Birth |  |
| Address |  |
| Previous Address |  |
| Telephone Number |  | Mobile Number |  |
| Email address |  |
| Contact/Communication Preference | Letter [ ]  Email [ ]  SMS [ ]  No Preference [ ]   |
| Marital Status | Single [ ]  Married [ ]  Divorced [ ]  Widowed [ ]  Cohabiting [ ]  Prefer not to say [ ]  |
| **Personal Medical History** |
| Name of your previous GP surgery |  |
| Address of previous GP surgery |  |
| Do you suffer from any of the following: | Heart Disease[ ]  Hypertension[ ]  Asthma[ ]  Diabetes[ ]  COPD[ ]  Chronic kidney disease[ ]  Epilepsy[ ]  Stroke[ ]  Cancer[ ]  Other[ ] If other, please state: |
| Do you have family history of: | Heart Disease[ ]  High Cholesterol[ ]  Heart Attack[ ]  Stroke[ ]  Cancer[ ]  Other[ ] If other, please state: |
| Allergies |  |
| List of Current Medication |  |
| **About Yourself** |
| Occupation |  |
| Are you a carer | Yes [ ]  No [ ]  | Do you have a carer? | Yes [ ]  No [ ]  |
| Carers details: Name and contact number |  |
| Are you happy for us to contact your carer about you? | Yes [ ]  No [ ]  |
| Ethnicity | White British[ ]  Irish[ ]  Other White Background[ ]  White & Black African[ ]  White & Black Caribbean[ ]  Other Mixed Background[ ]  Indian or British Indian[ ]  Pakistani or British Pakistani[ ]  Bangladeshi or British Bangladeshi[ ]  Other Asian Background[ ]  Black British[ ]  African[ ]  Caribbean[ ]  Chinese[ ]  Other[ ] If other, please state: |
| Main Spoken Language  |  | Do you speak English? | Yes [ ]  No [ ]  |
| Height (m) |  | Weight (kg) |  |
| Next of Kin Name |  |
| Relationship to Next of Kin |  |
| Next of Kin Tel. Contact Number |  | Are they registered here? | Yes [ ]  No [ ]  |
| **Lifestyle** |
| Smoking Status | Smoker[ ]  Never Smoked[ ]  Ex-Smoker[ ]  |
| If you’re a smoker do you smoke: | Cigarettes[ ]  Cigars[ ]  Pipe[ ]  Rollups[ ]  Vape[ ]  |
| How many cigarettes/cigars do you smoke daily? | <1/day[ ]  1-9/day[ ]  10-19/day[ ]  20-39/day[ ]  40+/day[ ]  |
| If you’re an ex-smoker when did you quit? |  |
| Would you like help to quit? | Yes [ ]  No [ ]  |
| Fast Alcohol Screening Test | For the following questions please **tick** the answer which best applies.**1 drink = ½ pint of beer or 1 glass of wine or 1 single spirits**How often do you have a drink containing alcohol?N/A[ ]  Never[ ]  Monthly or less[ ]  2 – 4 times per month[ ]  2 – 3 times per week[ ]  4+ times per week[ ] How many units of alcohol do you drink on a typical day when you are drinking?N/A[ ]  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?N/A[ ]  Never[ ]  Less than monthly[ ]  Monthly[ ]  Weekly[ ]  Daily or almost daily[ ] Alcohol intake:Teetotaller[ ]  Light drinker – 1-2u/day[ ]  Moderate drinker – 3-6u/day[ ]  Heavy drinker – 7-9u/day[ ]  |
| **Female Patients ONLY** |
| Are you currently pregnant? | Yes [ ]  No [ ]  |
| Do you have any children? | Yes [ ]  No [ ]  | If yes, how many? |  |
| Are you currently on contraception? | Yes [ ]  No [ ]   | If yes, what type? |  |
| Have you had a cervical smear test? | Yes [ ]  No [ ]  | If yes, What was the results? (if known) |  |
| Date (if known) |  |
| **Wider Determinants of Health** |
| Do you find it hard to understand information given to you about your health, or treatments you may be receiving? | Yes [ ]  No [ ]  |
| Are you having problems with your housing? | Yes [ ]  No [ ]  |
| Do you have difficulty making ends meet at the end of the month? | Yes [ ]  No [ ]  |
| Do you feel lonely? | Yes [ ]  No [ ]  |
| If you answered Yes to any of the questions, do you feel a referral for support would help?  | Yes [ ]  No [ ]  |
| **Consent and Data Sharing** |
| To maintain continuity of clinical care, we upload **certain** medical information so that it is available to other healthcare organisations (eg Emergency Departments). **Do you give us your consent to share certain medical information with other hospitals?**Yes [ ]  No [ ] Where you have provided information on how to contact you, can you confirm you are happy for The Broadway Surgery to contact you by the following:By email Yes [ ]  No [ ]  This will be to send you letters, newsletter and the like.By text Yes [ ]  No [ ]  This will be to send you reminders of appointments via text |
| I can confirm that the information I have provided is true to the best of my knowledge. |
| Signature |  | Date |  |
| Signature of Patient [ ]  Signature on behalf of patient [ ]  |