Marine Avenue Medical Centre

It may be some time before we receive your medical records. In the meantime we would be grateful if you could spend a few minutes filling in the following information. It will give doctors and nurses important information about your medical history and will help us to give a better service. The information you give will be in strictest confidence and used by your doctor or nurse.

<table>
<tr><td colspan="4">Today's Date:</td></tr>
<tr><td>Mr/Mrs/Miss/Ms
Other:</td><td colspan="2">Full Name:</td><td>Date of Birth :
Place of Birth:
If outside of UK date entered into UK:</td></tr>
<tr><td colspan="3">Address</td><td>Telephone No:
Home:
Mobile:</td></tr>
<tr><td>Height</td><td colspan="2">Weight</td><td>Email:
Do you wish to sign up for patient online access? YES/NO
Do you wish to sign up for EPS? YES/NO
<u>* PLEASE INFORM RECEPTIONIST FOR CONSENT PAPERS TO BE SIGNED</u></td></tr>
<tr><td colspan="3">Please list any special needs:</td><td>Are you a carer?
YES/ NO
Person you care for: .....

Name of next of kin: .....
Contact number.....
Relationship.....</td></tr>
<tr><td colspan="4">If you have suffered or are suffering from any of the following <u>please identify which and make an appointment with a doctor or nurse for an new patient check as soon as possible. If you fail to book or attend this appointment your registration will not be processed.</u>
Stroke / Heart Attack / Blood Pressure / Depression / Cancer / Epilepsy / Asthma / Angina / Thyroid Problems / COPD / Diabetes.

If you take any repeat medication and are unsure how it will continue with us please speak to a receptionist</td></tr>
<tr><td colspan="4">Please list any significant illnesses/operations you have had in the past:</td></tr>
<tr><td colspan="4">Please list any regular medication you are taking (either on prescription or bought over the counter.) Please attach an up to date back copy of any repeat prescription slips to ensure continuation of medication.
If necessary please cont medication on a separate sheet of paper & attach</td></tr>
<tr><td>Name of tablet/medicine</td><td colspan="2">Dose/strength</td><td>How many times a day</td></tr>
</table>

Please list any allergies you suffer from :

Do you smoke? YES / EX SMOKER / HAVE NEVER SMOKED TOBACCO
If yes how many cigarettes do you smoke a day?
If yes, please see reception for a leaflet regarding smoking cessation
If ex smoker when did you give up?

Questions | Scoring System | Your score

	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many units of alcohol so 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 drinks 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	

(1 unit = half pint of beer, 1 glass of wine, or a pub measure of spirits) Total score

If a close relative (Parent / Brother / Sister / Aunt / Uncle) has had any of the following please let us know which relative and how old they were when it happened.

ILLNESS	YES / NO	RELATIONSHIP	AGE
STROKE	YES / NO		
HEART ATTACK	YES / NO		
BREAST CANCER	YES / NO		
DIABETES	YES / NO		
BOWEL CANCER	YES / NO		
ASTHMA/COPD	YES please specify / NO		

Do you consent to us sharing your Summary care record in the event of an emergency (drug history, allergies etc)	YES/NO (**please ask reception for an opt out SCR FORM**)

Service (1) : Voice Calls/Text/Voice Text Messages
The GP Practice will on occasion wish to contact you via your mobile phone in order to notify you of such circumstances as appointment reminder, changes to your booked appointment, national issues such as Flu pandemics, flu clinics, the GP Practice being closed due to unforeseen circumstances etc. If you do not wish the GP Practice to contact you in this manner then please tick the box to the right: ☐

Thank you for taking the time to complete this form. Revised 22/09/2015