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| Preferred Contact Method*We may need to contact you from time to time to book or cancel appointments as well as send you news of services we offer* |
| Please select your preferred (1st choice) of communication |  **By text message** |  |
| **By telephone**  |  |
| **By email** |  |
| **By letter** |  |
| If you have additional needs, please tell us which way you would prefer us to communicate with you *You may choose more than one, but please make your preference clear* |  **With easy-read**  **pictures and words**  |  |
|   **With large text** |  |
|  **With sign**  **language**  **interpreter** |  |
| **Other -** *Please specify*  |
| Upon registration, we will automatically set you up for online services where you can view coded results, book appointments and order repeat prescriptions online. If you wish to opt out, please write ‘OPT OUT’ in the box.  |  |

**![C:\Users\kerry.harvey\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\M3W08GY0\ear[1].gif]()******![C:\Users\katy.gillingham\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\RCHJN8MO\email-letter-icon[1].jpg]()****![C:\Users\kerry.harvey\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\M3W08GY0\classic-telephone-silhouette[1].jpg]()![C:\Users\kerry.harvey\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\10S2ZK9D\images[1].jpeg]()**![C:\Users\kerry.harvey\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\10S2ZK9D\hand-symbol-silhouette[1].jpg]()**

**Please complete this form to the best of your knowledge and return to reception, with 1 form of photographic ID and 2 different proofs of current address (dated in the last 3 months).**

[**www.salisburymedicalpractice.co.uk**](http://www.salisburymedicalpractice.co.uk)

**01722 333034**

**bswicb.smp@nhs.net**

**Patient Information**

**Form**

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| **Personal Details** |
| **Title** *– Please Circle* | **Mr Mrs Ms Miss Other \_\_\_\_\_\_\_\_** |
| **First Name(s)** *– Please include any middle names* |  |
| **Surname** |  |
| **Previous surname** |  |
| **Preferred name** |  |
| **Date of Birth** |  |
| **First Spoken Language** |  |
| **Occupation** |  |
| **Marital Status***Please tick* |
| **Single** |  | **Married/Civil Partnership** |  |
| **Divorced** |  | **Widowed** |  |
| **Contact Details** |
| **Address** *Please include your postcode* |  |
| **Home phone number** |  |
| **Mobile phone number** |  |
| **Work phone number** |  |
| **Preferred telephone contact number** | **Home Mobile Work** |
| **By providing your telephone number, you give us permission to contact you. If you wish to opt out, please write ‘OPT OUT’ in box.** |  |
| **Email address** |  |
| **By providing your email address, you give us permission to contact you. If you wish to opt out, please write ‘OPT OUT’ in box.** |  |

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| **Immunisations – For children under 5 only***Please tick and provide dates where possible* |
| **Immunisation** | **Tick** | **Date** |
| **BCG (TB)** |  |  |
| **Hib** |  |  |
| **Measles** |  |  |
| **Meningitis** |  |  |
| **MMR** |  |  |
| **Polio** |  |  |
| **Tetanus** |  |  |
| **Whooping Cough** |  |  |
| **Diphtheria (booster)** |  |  |
| **MMR (booster)** |  |  |
| **Polio (booster)** |  |  |
| **Tetanus (booster)** |  |  |

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| **Your Lifestyle** |
| **Height (cm or ft)** | **Weight (kg or stone)** |
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| **Smoking** |
| **Which statement applies to you? Please tick** | **“I am a smoker”** |  |
| **“I am an ex-smoker”** |  |
| **“I have never smoked”** |  |
| **“I vape or use an e-cigarette”** |  |
| **If you used to smoke, when did you stop?** |  |
| **If you smoke, what do you smoke? Please tick** | **Packet cigarettes** |  | **Rolled cigarettes** |  |
| **Cigars** |  | **Pipe** |  |
| **E-cigarette/Vape** |  | **Other –** *please specify* |  |
| **If you smoke, how much do you smoke per day?** |  |
| **If you would like help to quit, please tick the box and we will contact you with an appointment** |  |
| **Alcohol**Your answers should reflect your activity in the past year |
| **How many units of alcohol do you drink per week?***(1unit = Half a pint of beer, one small glass of wine, or one single measure of spirit)* |  |
| **How often do you drink alcohol?** *Please tick* | **Never** |  | **Monthly or less** |  |
| **2-4 times a month** |  | **2-3 times a week** |  |
| **4 or more times a week** |  |
| **How many units of alcohol do you usually drink on a single occasion?***Please tick* | **N/A** |  | **1-2** |  |
| **3-4** |  | **5-6** |  |
| **7-9** |  | **10 or more** |  |
| **How often have you had 6+ units of alcohol if female, or 8+ if male, on a single occasion?** *Please tick* | **N/A** |  | **Never** |  |
| **Less than monthly**  |  | **Monthly** |  |
| **Weekly** |  | **Daily or almost daily** |  |

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| **Ethnicity***Optional – Please select one response* |
| **White or mixed British** |  | **White or mixed Irish** |  |
| **Other white background** |  | **Black African** |  |
| **Black and white African** |  | **Black Caribbean** |  |
| **Black and white Caribbean** |  | **Other black background** |  |
| **Chinese** |  | **White and Chinese** |  |
| **Indian** |  | **White and Indian** |  |
| **Pakistani** |  | **White and Pakistani** |  |
| **Other Asian background** |  | **Other Please specify** |
| **Military***By providing us with this information you will enable us to be able to treat you in accordance with the Military Covenant, we will also be able to provide you with details of support services and drop-ins specifically for veterans and the wider Armed Forces family* |
| **Are you a military veteran?** | **Yes No** |
| **Is your husband/wife/partner serving in the Armed Forces or a Veteran?** *With this information we will always ensure you receive the best advice for your personal circumstances.* | **Yes No** |
| **Are you a Carer for a veteran/serving member of the Armed Forces?** | **Yes No** |
| **Carers***We hold various events and clinics specifically for Carers so by letting us know if you care for someone who could not otherwise manage without you we will ensure you receive information to support you.* |
| **Are you a Carer?** | **Yes No** |
| **If you circled ‘Yes’, please state the name of the person you care for.** |  |
| **If you are a carer, do you consent to this information being held on our carer’s register? –***This will enable us to ensure you receive invites to events and personalised care.* | **Yes No** |
| **Do you have a carer?** | **Yes No** |
| **If you circled ‘Yes’, please state the name of the person who cares for you** |  |

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| **Information Sharing***This can ONLY be completed by the patient; whom has capacity to make this decision. Do not complete on behalf of someone else.* *Please ensure that you sign in each signature block.*  |
| **Do you consent to share information with other Health and Social care professionals and organisations?** | **Yes No** |
| **Do you consent to share information with a named third party individual, such as a relative, carer or friend?***If you wish to nominate additional parties, please request additional information sharing sheets from Reception.*  | **Yes No** |
| **If you circled ‘Yes’, please state the name of your third party individual** |  |
| **Relationship to third party individual** |  |
| **Address for third party individual** |  |
| **Phone number for third party individual** |  |
| **Signature** |  | **Date** |  |
| **Is your named third party individual your next of kin?** | **Yes No** |
| **If you circled ‘No’, please state the name of your next of kin** |  |
| **Relationship to next of kin** |  |
| **Address for next of kin** |  |
| **Phone number for next of kin** |  |
| **Signature** |  | **Date** |  |

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| **Personal Medical History** |
| **Do you suffer with any of the following illnesses?***Please tick* |
| **Asthma** |  | **Epilepsy** |  |
| **Heart disease** |  | **Mental health problems** |  |
| **Osteoporosis** |  | **Raised blood pressure** |  |
| **Raised cholesterol** |  | **Stroke** |  |
| **Thyroid disease** |  | **Type 1 Diabetes** |  |
| **Type 2 Diabetes** |  | **Other** |  |
| **If you ticked ‘Other’, please specify** |  |
| **If you have allergies, please state them** |  |
| **Family Medical History** |
| **Is there any history in your family of the following illnesses?***Please tick* |
| **Asthma** |  | **Coronary heart disease** |  |
| **Diabetes** |  | **Heart attack** |  |
| **Raised blood pressure** |  | **Raised cholesterol** |  |
| **Stroke** |  | **Other** |  |
| **If you ticked ‘Other’, please specify** |  |
| **Prescriptions** |
| **Please state the name of the Pharmacy that you would like your prescriptions to be sent electronically to**  |  |





