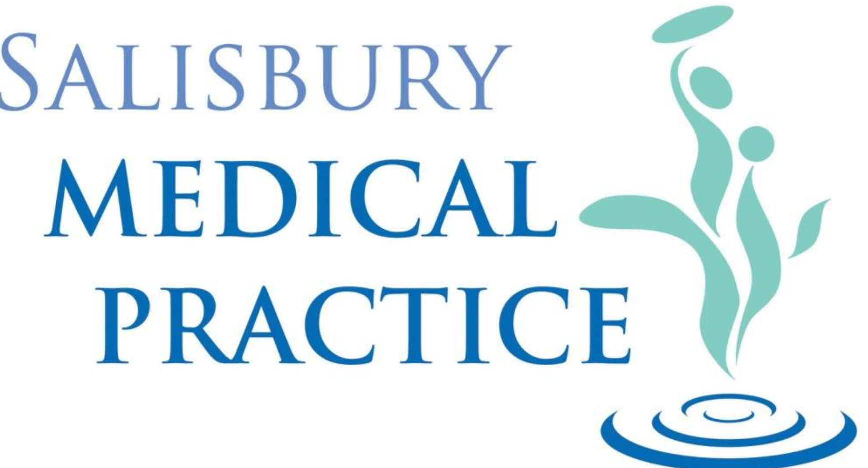
Request preferred contact method

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*	

From 1st April 2019, 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.	

Updated: April 2019 Review date: April 2020



Patient Information Form

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.

www.salisburymedicalpractice.co.uk
01722 333034
Wccg.smp@nhs.net

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.	

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)		

Your Lifestyle

Height (cm or ft)	Weight (kg or stone)

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	

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	

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**	

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	