

SALISBURY MEDICAL PRACTICE









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

Preferred Contact Method <i>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</i>	
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 <i>You may choose more than one, but please make your preference clear</i>	 With easy-read pictures and words
	AA 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.	

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 <i>Please tick</i>			
Single	<input type="checkbox"/>	Married/Civil Partnership	<input type="checkbox"/>
Divorced	<input type="checkbox"/>	Widowed	<input type="checkbox"/>
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 <i>Please tick and provide dates where possible</i>		
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? <i>(1 unit = Half a pint of beer, one small glass of wine, or one single measure of spirit)</i>			
How often do you drink alcohol? <i>Please tick</i>	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? <i>Please tick</i>	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? <i>Please tick</i>	N/A		Never
	Less than monthly		Monthly
	Weekly		Daily or almost daily

Ethnicity			
<i>Optional – Please select one response</i>			
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			
<i>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</i>			
Are you a military veteran?		Yes	No
Is your husband/wife/partner serving in the Armed Forces or a Veteran? <i>With this information we will always ensure you receive the best advice for your personal circumstances.</i>		Yes	No
Are you a Carer for a veteran/serving member of the Armed Forces?		Yes	No
Carers			
<i>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</i>			
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? – <i>This will enable us to ensure you receive invites to events and personalised care.</i>		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? <i>If you wish to nominate additional parties, please request additional information sharing sheets from Reception.</i>	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	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	Mental health problems	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	Raised blood pressure	<input type="checkbox"/>
Raised cholesterol	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	Type 1 Diabetes	<input type="checkbox"/>
Type 2 Diabetes	<input type="checkbox"/>	Other	<input type="checkbox"/>
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	<input type="checkbox"/>	Coronary heart disease	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>
Raised blood pressure	<input type="checkbox"/>	Raised cholesterol	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	Other	<input type="checkbox"/>
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

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