**Broadway Surgery New Patient Registration – Adult**

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

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | | | | | | | | | | |