Meopham Medical Centre

Wrotham Road Meopham Kent DA13 0AH
Phone: Appointments 01474 814811 Enquiries 01474 814288

New Patient Registration Over 16 years

About you

Surname: …… Forename(s): ……

Date of Birth (dd/mm/yyyy): ……...

Gender: ……

Contact Information

Address:……

Telephone: …… Mobile: ……

Email: ……

Please circle below your preferred choice of contact:

Text Phone

Do you live in a residential/nursing home? **Yes** ☐ **No** ☐

What is your occupation?.....

Service Families and Military Veterans

As a practice, we fully support the Armed Forces Covenant. We can only do this if we know our patients connections to the Armed Forces. Please tick the below boxes that apply to you:

I AM a Military Veteran		**I AM** currently serving in the Reserve Forces	
I AM married/civil partnership to a serving member of the Regular/Reserve Armed Forces		**I AM** married/civil partnership to a Military Veteran	
I AM under 18 and my parent(s) are serving member(s) of the armed forces.		**I AM** under 18 and my parent(s) are veteran(s) of the armed forces.	

Ethnicity

Having information about patients' ethnic groups would be helpful for the NHS so that it can plan and provide culturally appropriate and better services to meet patients' needs.

If you do not wish to provide this information you do not have to do so.

Please indicate your ethnic origin by ticking the below box:

British or mixed British		Pakistani	
Irish		Bangladeshi	
African		Chinese	
Caribbean		Other (Please state)	
Indian			

Country of birth

In which country were you born?.....

Main language

Which is your main language?.....

Do you speak English?.....

Carer status

Do you have a carer? **Yes** ☐ **No** ☐

If Yes, please give details of their name, relationship and whther they are a patient here too……..

Are you yourself a carer? **Yes** ☐ **No** ☐

Next of kin

Surname: …… Forename(s): ……

Gender: ……

Emergency contact Information (for next of kin)

Telephone: …… Mobile: ……

Contacting you

We will use your contact details to send reminders about appointments, reviews and other services which may be of benefit in your medical care

Do you consent to the Surgery sending letters to your home address? **Yes** ☐ **No** ☐

Do you consent to the Surgery sending text messages to your mobile? **Yes** ☐ **No** ☐

Do you consent to the Surgery sending messages to you by email? **Yes** ☐ **No** ☐

Do you consent to the Surgery leaving messages on your phone? **Yes** ☐ **No** ☐

(We will not leave detailed messages on your phone, but may ask you to contact us or leave a simple message if we do not need to speak to you).

Summary Care Record

Summary Care Record (SCR)
If you decide to have a SCR, it will contain important information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines that you have had it will also include basic information about your current diagnoses. Giving healthcare staff access to this information can prevent mistakes being made when caring for you in an emergency or when your GP practice is closed. Your Summary Care Record will also include your name, address, date of birth and your unique NHS Number to help identify you correctly. If you and your GP decide to include more information it can be added, but only with your express permission.

For more information: Phone 0300 123 3020 or visit www.nhscarerecords.nhs.uk

I do not wish to have a Summary care Record
(N.B. this will mean NHS Healthcare staff caring for you may not be aware of your current medications, any allergies or reactions to previous medication.)

I wish to opt out of SCR ☐

Electronic Prescribing Service (EPS)

The EPS allows prescribers – such as GPs and practice nurses to send prescriptions electronically to a dispenser (such as a pharmacy) of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff. The NHS aim that by 2020 they will hopefully be paper free or a paper-lite service. To help achieve this The As a practice, we would encourage all patients to opt for electronic prescribing.

☐ **I DO** give consent for my prescriptions to be sent electronically to the pharmacy

☐ **I DO NOT** give consent for my prescriptions to be sent electronically to the pharmacy

Nominated pharmacy……

Address……

Postcode……

Resuscitation wishes and Power of Attorney

Do you have a DNACPR (Do not attempt CPR) form in place? **Yes** ☐ **No** ☐

Does anybody hold Lasting Power of Attorney for Health and Welfare for you? **Yes** ☐ **No** ☐

If **YES to either of the above questions**, please supply details of who holds this and where (and supply a copy for your medical notes).
Details……

Smoking status

Do you smoke? **Yes** ☐ **No** ☐

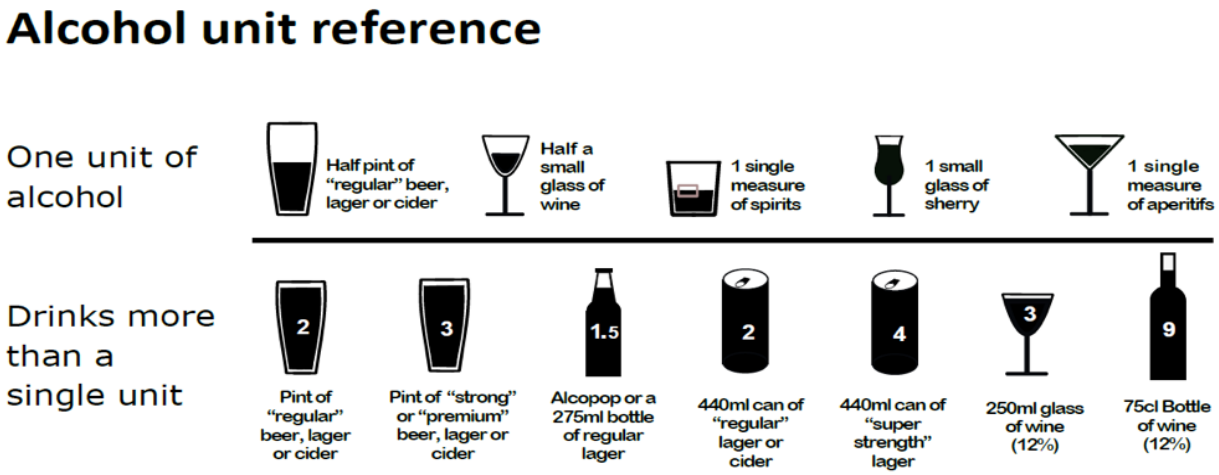
If yes, how many cigarettes do you smoke daily: ……

If no, have you smoked in the past? **Yes** ☐ **No** ☐

Smoking is the UK's single greatest cause of preventable illness
Stopping smoking is not easy but it can be done, and there is now a comprehensive, NHS Smoking Cessation Service offering support and help to smokers wanting to stop, with cessation aids available on NHS prescription.

If you would like help and advice on how to give up smoking, please contact https://www.quit4life.nhs.uk/ or ask at reception.

Alcohol intake



Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink that contains alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many alcoholic drinks do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring

Score: …….

A total of 5+ indicates increasing or higher risk drinking. If you have a score of 5+ please complete the remaining questions below.

Questions	Scoring system					Your score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Questions	**Scoring system**					**Your score**
	0	**1**	**2**	**3**	**4**	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Please add up your scores from the above tables and write the total below:
Total……..

If you would like help and advice on how to reduce your alcohol intake, please contact https://www.drinkaware.co.uk/ or ask at reception.

Height/Weight

What is your height: …….

What is your weight:……..

If you would like advice on managing a healthy weight, please contact https://www.nhs.uk/live-well/ or reception who will be able to direct you to the most appropriate service.

Disabilities / Accessible Information Standards

As a practice we want to make sure that we give you information that is clear to you. For that reason we would like to know if you have any communication needs.

Do you have any special communication needs?

Yes ☐ **No** ☐

If yes, please state your needs below:

……..

Do you have significant mobility issues? **Yes** ☐ **No** ☐

If yes, are you housebound? **Yes** ☐ **No** ☐
(Definition of housebound - A patient is unable to leave their home due to physical or psychological illness)

Are you blind/partially sighted? **Yes** ☐ **No** ☐

Do you have significant problems with your hearing? **Yes** ☐ **No** ☐

Transfusion history

Did you have a blood transfusion before 1991? **Yes** ☐ **No** ☐

Family History and past medical history

Have any close relatives (parent, sibling or child only) ever suffered from any of the following?

Condition	Yes	No
Heart Disease (Heart attack/Angina)		
Stroke		
Diabetes		
Asthma		
Cancer		

Have you yourself ever suffered from any important medical illness, operation or admission to hospital? **If so** please enter details below:

Condition	Year diagnosed	Ongoing?

Allergies

Please list any drug or food allergies that you have:
……
……
……

Medications
Please provide a list of repeat medications:
……
……
……

For female patients only

Are you currently pregnant? **Yes** ☐ **No** ☐

If yes, *please ensure you are under the care of a midwife. If you're not currently under the care of a midwife please speak to reception regarding this.*

Which method of contraception (if any) are you using at present?

……

Do you currently have long acting reversible contraception in place? *(Implant/Coil)*

Yes ☐ **No** ☐

If yes, when was this fitted? (dd/mm/yy)

……
Have you had a cervical smear test? **Yes** ☐ **No** ☐

If yes, when was this last done? (dd/mm/yy)

……

Have you had a hysterectomy? **Yes** ☐ **No** ☐

Do you still have your ovaries? **Yes** ☐ **No** ☐