BIRDHURST MEDICAL PRACTICE

1 Birdhurst Avenue, South Croydon, Surrey CR2 7DX
Tel: 020-8686-2070 Fax: 020-8686-0824

Thank you for applying to register with the Birdhurst Medical Practice.

We would like you to answer the questions on both sides of this form. Please hand it in at reception when you have completed it. The answers will help us to provide you with good medical care.

Dr Camilla Chambers Dr Doyin Okuboyejo Dr Vaishali Shetty

Mr/Mrs/Ms/Miss …….. **LAST NAME:** ……
or other title

FIRST NAMES: ……

ANY PREVIOUS NAMES: …….

DATE OF BIRTH: **SEX: M/F**

CONTACT TEL NOS: Home…….. **Mobile**……..……

Email Address ……..

ADDRESS ……..

…….. **POSTCODE:**……..

EMERGENCY CONTACT …… **TEL NO.** ……..……..

RELATIONSHIP TO YOU …….

CARERS NAME ……. **TEL NO.** ……
(If applicable)

ARE YOU A CARER? Do you look after a friend or relative Yes / No

ETHNIC ORIGIN: White British ( ) White Irish ( ) Other White British ( ) White Ethnic ( )

Please tick box Black British ( ) Black Caribbean ( ) Black/White Caribbean ( )

Black/White African ( ) Black African ( ) Black/Other mixed ( ) Indian ( )

Pakistani ( ) Bangladeshi ( ) British Asian ( ) Other Asian ( )

Chinese ( ) Any Other Ethnic Group ( )

FIRST LANGUAGE SPOKEN: …….

MARITAL STATUS: Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed ( ) Civil Partnership ( )

OCCUPATION: **……**

Please tick if you would like to opt out of Summary Care Records ( ) ask reception if you require more information

Please tick if you would like to opt out of sharing your patient non identifiable data ( )

Please indicate why you chose to register with us:-
Recommendation ( ) Randomly selected from list of local surgeries ( ) Nearest surgery to where you live ( )
Other – please indicate ……

PTO

MEDICAL INFORMATION:

Do you suffer from any of the following medical problems:-

Previous Medical Problem	YES	NO	Previous Medical Problem	YES	NO
High Blood Pressure			Thyroid problems		
Angina or Heart Attack			Epilepsy		
Stroke			Depression		
Diabetes (Non-insulin dependant)			Mental Illness		
Diabetes (Insulin dependant)			Asthma or C O P D		
Other / Allergies			Major operations		

Are you taking any regular or repeat medication?

If **YES** please make an appointment with a doctor **before** requesting any further medication.
If **NO** please make an appointment with our Health Care Assistant for a new patient health check.

Do you have any allergies? Please List: ……..

Do you have any Information or Communication needs relating to disability, impairment or sensory loss?
If yes, then please describe/list: **……..**

Has anyone in your immediate family (mother, father, brothers or sisters) had any of the following:-

High Blood Pressure	No ( )	If yes - Who?……..Age when diagnosed……
Angina or heart attack	No ( )	If yes - Who?……..Age when diagnosed……
Stroke	No ( )	If yes - Who?……..Age when diagnosed……
High level of cholesterol	No ( )	If yes - Who?……..Age when diagnosed……
Diabetes	No ( )	If yes - Who?……..Age when diagnosed……
Asthma	No ( )	If yes - Who?……..Age when diagnosed……
Thyroid problems	No ( )	If yes - Who?……..Age when diagnosed……
Breast cancer	No ( )	If yes - Who?……..Age when diagnosed……
Bowel Cancer	No ( )	If yes - Who?……..Age when diagnosed……
Cancer – other	No ( )	If yes - Who?……..Age…….Type…….

Do you smoke? Yes ( ) No ( ) If yes, how many per day?…...……

If you used to smoke, when did you give up? ……

If you are a smoker, we would like to stress the dangers of smoking, which can lead to major health problems and prove fatal. We would encourage you to give up smoking and can offer you advise.

Do you drink alcohol? No ( ) Yes ( ) (Please complete the following)

Questions	0	1	2	3	4	Practice Use Only
How often do you have a drink that contains alcohol?	Never	Monthly or Less	2-4 times a month	2-3 times a week	4+ times a week	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

LADIES (please tick relevant boxes)

Have you ever had a cervical smear? Yes ( ) No ( ) If yes, Date taken ……
Where was it taken? GP surgery ( ) Clinic ( ) Hospital ( )
Was it normal? Yes ( ) No ( )