

Drayton & St Faiths Medical Practice

Welcome and thank you for registering with the Drayton & St Faiths Medical Practice. We would be grateful if you could spend a few moments answering the following questions. This will allow us to update our patient record whilst we wait for your medical records.

Please mark a \surd or enter a value as appropriate. This information will be held in your personal health record which, like all NHS records, remain confidential. Once complete, please return this form to one of our receptionists.

For more information about the Practice, please ask at reception for a Practice Information Leaflet, or if you have internet access you can view our website at www.drayton-stfaiths.co.uk.

Name:

Date of Birth : ___ / ___ / _____ (dd-mm-yyyy)

Occupation _____

Mobile Number _____

Work Telephone Number _____

The Practice website has an "Appointments Online" section. If you choose to sign up for this, you will be able to book, view and cancel appointments via the internet. You will also be able to use "Appointments Online" to view and re-order any repeat prescriptions you may have. We are also able to send reminders about upcoming appointments to your mobile phone.

Would you like to access Appointments Online?

Would you like to receive SMS reminders?

Height _____ Weight _____

Smoking History

Never Smoked Ex-Smoker

Current Smoker (number per day) _____

Type: Cigarettes / cigars / pipe / roll-ups

We strongly recommend that patients do not smoke. If you would like advice or help to stop smoking please enquire at reception for details of our smoking cessation services.

Alcohol

Approximately how many units of alcohol do you have per week?

What type of alcohol do you drink?

Beers / Wines / Spirits / Alco pops / Other

Exercise

Summary Care Record

Please indicate here if you have previously opted out of the Summary Care Record

Please indicate here if you do **NOT** want a Summary Care Record

Allergies

Do you have any allergies?

Animals / pollen / nuts / medication / latex / other (please specify)

Have you ever suffered from a bad reaction to any medication?

Yes / No (if yes, please give details)

Date of last Cervical Smear:

Date of last blood pressure check:

Date of last tetanus injection:

Date of last cholesterol check:

Date of last 'flu vaccination:

Date of last pneumococcal vaccination:

Carers

Do you look after or support somebody who is ill, frail, disabled or mentally ill? Yes / No

If you require any further information or advice about being a carer, please ask a receptionist for one of our carer packs

The Government now requires GP Practices to record the Ethnic origin and First Language of all our patients.

We would be grateful if you would fill in the boxes below . We will record this information on your medical record but any data given to the Government will be anonymised

I do NOT wish to disclose this information

White

British Irish

Any other white background
(please write in)

Mixed

White and Black Caribbean

White and Black African

White and Asian

Any other mixed background
(please write in)

Asian or Asian British

Indian Pakistani

Bangladeshi

Any other Asian Background
(please write in)

Black or Black British

Caribbean African

Any other Black Background
(please write in)

Chinese or other ethnic group

Chinese

Any other (please write in)

First Language Spoken :