SUMMERCROFT SURGERY

Adult Application

Title: ..... **First Name:** ..... **Surname:** .....

Middle Name (S): ..... **Date of Birth:** .....

NHS Number: ..... **Gender:** ☐ **Male** ☐ **Female**

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Co-Habiting

Is your main language English? ☐ **Yes** ☐ **No** **If no, please state main language:** .....

Do you require an interpreter? ☐ **Yes** ☐ **No**

Ethnicity:

☐ British or mixed British	☐ Irish	☐ Other White background	
☐ White and Black Caribbean	☐ White and Black African	☐ White and Asian	☐ Other mixed background
☐ Indian or British Indian	☐ Pakistani or British Pakistani	☐ Bangladeshi or British Bangladeshi	☐ Other Asian background
☐ Caribbean	☐ African	☐ Other Black background	
☐ Chinese	☐ Other	☐ Prefer not to say	

Contact Details

House Name/Flat Number: .....

Door Number & Street: .....

Locality: .....

Town/City: .....

County: .....

Postcode: .....

Home Phone Number: .....

Work number: .....

Mobile Number: .....

Can we contact you via SMS Messages? ☐ Yes ☐ No

Email Address: .....

Can we contact you via E-mail? ☐ Yes ☐ No

Previous/Temporary Address:

House Name/Flat Number: .....

Door Number & Street: .....

Locality: .....

Town/City: .....

County: .....

Postcode:

Would you like EMIS Access? ☐ Yes ☐ No

Date of Enlistment into the Armed Services: .....

Date entered Country, if from outside of EU:

Your Health

Approx. height: ..... Feet ..... Lbs **OR** ..... CM
Approx. weight: ..... Stone ..... **OR** ..... KG

Do you currently smoke? ☐ Yes ☐ No If yes how many?

If you are an ex-smoker, how many did you previously smoke? .....
Which year did you give up? .....

How many units of alcohol do you take per week on average? .....
1 Unit = ½ pint of beer, 1 small glass of wine, 1 pub measure of spirit

Are you being treated for or have you ever had treatment for any of the following conditions:

Angina	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Depression	☐ Yes	☐ No		☐ Yes	☐ No

HIV - Adult in London are being offered a free HIV test when registering with a new GP. This is recommended by the Department of Health as 100,000 people in the UK are living with HIV, half of them live in London and 1 in 5 do not know they have it.
Do you know your HIV status? ☐ Yes ☐ No *If not would you like to be tested?* ☐ Yes ☐ No

Chlamydia Screening Test (16-24years only)
We are offering free STI screening to patients between 16-24 years due to rising rates of sexual transmitted infections. Often patients have no symptoms but the implications of being untreated can have serious long term consequences including infertility.
Would you like to have a chlamydia screening test? ☐ Yes ☐ No

New Patient Health Check – Would you like a new patient health check ☐ Yes ☐ No

Please list any other illnesses, accidents, hospital admissions, operations, broken bones, serious infections or investigation:

Date/Year	Nature of illness

Allergies

Please list all allergies e.g. medications, hay fever, food, animals, ect

Family History

Have any of you blood relatives ever suffered from:

			Type:	**Relationship**	**Age at diagnosis**
Cancer, which type?	☐ Yes	☐ No	• ..... • ..... •	• ..... • ..... •	• ..... • ..... •
Diabetes, which type?	☐ Yes	☐ No	•	•	•
Heart Attack / Angina / Heart Bypass/Stent	☐ Yes	☐ No	• ..... •	• ..... •	• ..... •
High Blood Pressure	☐ Yes	☐ No	•	•	•
Stroke	☐ Yes	☐ No	•	•	•

Medication

If you are on any regular medication please attach you repeat prescription slip from your last practice. If you do not have one, please list any medication which you use regularly.

Drug Name	Form – tablet, cream	Strength	Amount taken per day

Carers

Do you have a carer? ☐ Yes ☐ No If yes please give details .....

Are you a carer? ☐ Yes ☐ No If yes please give details .....

Emergency Contact/Next of kin

Name: .....

Relationship: .....

Telephone: (if different to yours) ..... Home ..... Mobile

Address: (if different to yours) .....

Are they a patient at the surgery? ☐ Yes ☐ No

Summary Care Records

This Practice is Summary Care Records live, which means that your prescriptions, allergies and adverse reactions are saved on a central database for use of A&E and other care professionals if your require treatment when the surgery is closed. Please select which of the below is your preference.

☐ Express consent for medication, allergies, and adverse reactions only

☐ Express consent for medication, allergies, and adverse reactions, AND additional information

☐ Express dissent **(opted out)** – Patient does **NOT** want a summary care record (*forms at reception*)

Patient Participation Group (PPG)

If you would like to join out PPG please enquire at Reception, in event you are interest but would be unable to attend meeting due to other commitments we would welcome your input via e-mail.

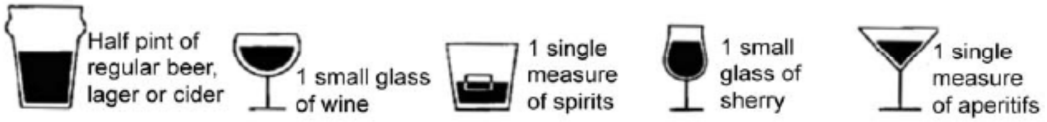
Please present this form along with your GMS1 Form, NHS Number, photographic identification and proof of address.

FOR OFFICE USE ONLY

☐ **Photo ID** ☐ **Proof of address** ☐ **Informed Named GP** ☐ **NHS Number**

Receptionist **Date**

This is one unit of alcohol...



...and each of these is more than one unit

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	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?	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?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

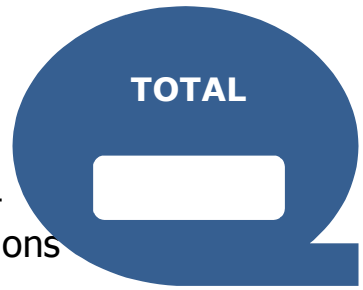
Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

Score from AUDIT- C (other side)

Remaining AUDIT questions

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	
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	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 Higher risk, 20+ Possible dependence



TOTAL Score equals
AUDIT C Score (above) +
Score of remaining questions