**TO BE FILLED IN BY ALL NEW PATIENTS WHEN REGISTERING AT THE PRACTICE**

**Please fill out as much as possible**

Do you have any special communication needs? 🞏 Yes 🞏 No

If yes, please state ……………………………………………………………………………

|  |  |
| --- | --- |
| Height in Metres/Feet |  |
| Weight in Kilograms/Stones |  |
| BP reading (if over 18) |  |

|  |
| --- |
| **Smoking status: (please circle)** |
| Smoker | Never Smoked |
| Ex Smoker Please state date/month/year stopped  |

Smoking cessation advice wanted? (please circle) *YES (Ua1Nz) Decline (XaRFh)*

**Consent for Data Sharing (please circle)** YES (XaKRv) NO (XaKRw)

**GDPR – Information sheet read**: YES

|  |
| --- |
| **Alcohol Consumption (please circle)** |
| How often do you have a drink containing Alcohol? | N/A |
| Never |
| Monthly or less (1) |
| 2-4 times a month (2) |
| 2-3 times a week (3) |
| 4 or more times a week (4) |
| How many units of alcohol do you drink on a typical day When you are drinking? | N/A |
| 1 or 2 (0) |
| 3 or 4 (1) |
| 5 or 6 (2) |
| 7 or 8 (3) |
| 10 or more (4) |
| How often have you had 6 or more units if female,or 8 or more units if maleOn a single occasion in the last year? | N/A |
| Never (0) |
| Less Monthly (1) |
| Monthly (2) |
| Weekly (3) |
| Alcohol use disorder identification testConsumption questionnaire | Total Score |
|  |
| Total 7 or above to be offered HCA appointment | Appt Made Appt Declined |

*Please let us know if you have any allergies so these can be put on your records straight away*

**Any Allergies (please state) ……………………………………………………………………………………………..**

Nominated Romsey Pharmacy for patients with repeat prescriptions

(Please circle)

BOOTS ROMSEY PHARMACY

SUPERDRUG NIGHTINGALE PHARMACY

|  |
| --- |
| **Please tick if you have any of the following conditions:-**  |
| Diabetes  |  |
| Asthma |  |
| Stroke or TIA |  |
| Chronic Heart disease |  |
| Chronic Obstructive Pulmonary Disease (COPD/Lung disorder) |  |
| Hypertension (on medication for high blood pressure) |  |

**ALMA ROAD SURGERY – MOBILE PHONE/E-MAIL CONSENT FORM FOR TEXT/MESSAGES**

Alma Road Surgery may wish to send text or voice messages to your mobile, or e-mail you to notify you of changes to appointments, or remind you of booked appointments in specific clinics.

I agree to Alma Road Surgery contacting me in this manner (please circle) YES: XaQid NO: XaQmZ

|  |  |
| --- | --- |
| Name | DOB |
| Signature  |  |
| Mobile Number  |
| E-mail address |

**Your Next of Kin details**

|  |
| --- |
| Name  |
| Contact number of Next of Kin | Relationship |

*Disclaimer*

*If you agree to Alma Road Surgery contacting you via your mobile phone/e-mail, we agree to adhere to the following:-*

1. *The mobile phone number and e-mail address will only be used by us in relation to your Healthcare services and will not be passed to any other parties.*
2. *If at any time you would like to opt out of the above service, please make a personal request to us and you will be opted out of the service within 48 hours. You may also like to include your reason for opting out to help us review and improve the service in future.*
3. *Your mobile phone number/e-mail will solely be used by the Practice in relation to the Healthcare services offered by the GP practice.*
4. ***Alma Road Surgery cannot be held responsible if YOU DO NOT notify us if you change your mobile number or e-mail address.***

|  |
| --- |
| ***Office use only:-*** |
| *Named and accountable GP (XacWQ)* |
| ***Identification seen:-*** |
| *Passport* | *Driving licence* | *Utility Bill* | *Other (please state)* |