



Emis No.:

Billesdon Surgery

4 Market Place, Billesdon, Leicester, LE7 9AJ

Tel: 0116 2596206, Web: www.billesdonsurgery.co.uk

Thank you for applying to join Billesdon Surgery. We would like to gather some information about you and ask that you fill in the following questionnaire. You don't have to supply answers to all of the questions but what you do fill in will help us give you the best possible care. **You must supply IN PERSON 2 forms of Identification with your completed form, a photographic ID (such as a PASSPORT or DRIVING LICENSE) and proof of your home address (such as a recent BANK STATEMENT or UTILITY BILL).**

Please complete all areas in **CAPITAL LETTERS** and tick the appropriate boxes. Please ensure you SIGN and DATE your form.

****YOU ARE REQUIRED TO FILL IN THE FIELDS MARKED WITH AN ASTERISK (*), FAILURE TO DO SO MAY DELAY YOUR REGISTRATION****

*Title:	*Surname:
*Any previous surname(s) (if applicable):	
* <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intermediate <input type="checkbox"/> Unspecified	
*Town and country of birth:	
*Home telephone No.:	
Work telephone No.:	
*Mobile No. (if you have one):	

*First names:
*Date of Birth:
*NHS No. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
*Home address & Postcode:
*Previous address & Postcode:
Email address:

*Previous GP Details (name and address):
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*If you are from abroad please tell us your <u>first</u> UK address where registered with a GP:
*If previously resident in UK, date of leaving:
*Date you first came to live in the UK:

Tick this box if you have ever been in the employ of the Armed Forces <input type="checkbox"/>
Personnel number: _____ Date enlisted: _____ Date left the armed forces: _____
Tick this box if you are a dependant of a current serving member of the British Armed Forces <input type="checkbox"/>

Additional details about you

What is your ethnic group?	Main spoken language (E.g. English):
White <input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> Other White (please specify):	
Black <input type="checkbox"/> Caribbean <input type="checkbox"/> African <input type="checkbox"/> Other Black (please specify):	
Asian <input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Chinese <input type="checkbox"/> Other Asian (please specify):	
Mixed <input type="checkbox"/> White + Black Caribbean <input type="checkbox"/> White + African <input type="checkbox"/> White + Asian <input type="checkbox"/> Other mixed:	

Height	ft	in
Weight	st	lb
Waist measurement	in	

(for women only) Have you had a cervical smear?
<input type="checkbox"/> Yes <input type="checkbox"/> No (Please state where, when and the result if possible)

Next Of Kin / Emergency contact

1	Name / Relationship to you / Telephone No. / Address (if different to yours)
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2	Name / Relationship to you / Telephone No. / Address (if different to yours)
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Carers Information

A carer is a friend / family member who gives their time to support a person in their home, to an extent that the person could not remain at home if this care was not being provided. A carer can receive Carers Allowance (but not a wage) and the care they are giving will significantly affect their own life.

Are you looked after by someone who's support you could not manage without? Yes No
 If yes, what is their name and contact number?
 Do you consent for your carer to be informed about your medical care? Yes No

Do you look after or support someone who couldn't manage without you? Yes No
 If yes, do you look after someone who is a patient of Billesdon Surgery? Yes No Don't know
 If yes, what is their name:
 Are they a, Friend Relative Neighbour

Medical details

In order to continue to receive your repeat medications you'll need to make an appointment with a GP at least one week before your next prescription is due.

*Are you allergic to any medicines? Yes No (if yes please specify)

*List other allergies / intolerances (i.e pollen, animal hair or certain foods. Please mark "none" if you have no other allergies that you know of) :

Have you ever had any of the following conditions?

Epilepsy	<input type="checkbox"/> Yes	Year
High Blood Pressure	<input type="checkbox"/> Yes	Year
Heart Attack / Angina	<input type="checkbox"/> Yes	Year
Stroke / Mini-Stroke (TIA)	<input type="checkbox"/> Yes	Year
Cancer	<input type="checkbox"/> Yes	Year
Rheumatoid Arthritis	<input type="checkbox"/> Yes	Year

Mental Illness (inc Depression)	<input type="checkbox"/> Yes	Year
Diabetes (type 1 or type 2)	<input type="checkbox"/> Yes	Year
Asthma	<input type="checkbox"/> Yes	Year
COPD (or Emphysema)	<input type="checkbox"/> Yes	Year
Osteoporosis / Bone Fractures	<input type="checkbox"/> Yes	Year
Peripheral Vascular Disease	<input type="checkbox"/> Yes	Year

List any serious illnesses / operations / accidents / disabilities (women: any pregnancy related problems) & the year they took place:

Do you have any disabilities, illnesses or accessibility needs? I.e. needing to be seen in ground floor consulting rooms or use of a specific communication device such as a hearing aid? If yes, please tell us how we can support your needs:

Do you have Family History of any of the following?

High Blood Pressure	<input type="checkbox"/> Yes	Who
Ischaemic Heart Disease Diagnosed aged >60 yrs	<input type="checkbox"/> Yes	Who
Ischaemic Heart Disease Diagnosed aged <60 yrs	<input type="checkbox"/> Yes	Who
Raised Cholesterol	<input type="checkbox"/> Yes	Who
Stroke / CVA	<input type="checkbox"/> Yes	Who
Asthma	<input type="checkbox"/> Yes	Who

DVT / Pulmonary Embolism	<input type="checkbox"/> Yes	Who
Breast Cancer	<input type="checkbox"/> Yes	Who
Any Cancer Specify type:	<input type="checkbox"/> Yes	Who
Thyroid disorder	<input type="checkbox"/> Yes	Who
Epilepsy	<input type="checkbox"/> Yes	Who
Osteoporosis	<input type="checkbox"/> Yes	Who

Please tell us about your smoking habits

*Do you smoke? Yes No
 If Yes, what do you primarily smoke:
 Cigarettes / Cigar / Pipe (please circle)
 How many do you smoke a day?
 Would you like advice on quitting? Yes No

Are you an ex-smoker Yes No
 When did you quit?
 How many did you used to smoke a day?

Please tell us about your alcohol consumption

1 Unit = Normal half pint beer (284ml) 4% or Single shot spirit (25ml) 40%. **1.5 Units** = Small glass of wine (125ml) 12.5% or Alcopop (275ml) 5.5%.
2 Units = Strong half pint beer (284ml) 6.5% or Medium glass of wine (175ml) 12.5% or Normal large bottle/can beer (440ml) 4.5%
3 Units = Strong bottle/can beer (440ml) 6.5% or Bottle of wine (750ml) 12.5% or Bottle spirits (750ml) 40% or Large glass of wine (250ml) 12.5%

Questions (please circle your answers in the boxes below)	Unit scoring system				
	0	1	2	3	4
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times Per month	2 - 4 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

IF YOU SCORE A TOTAL OF 5 OR MORE ON THE ABOVE QUESTIONS, PLEASE COMPLETE THE FURTHER 7 QUESTIONS BELOW

How often in 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 in the last year have you failed to do what was expected of you because of drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
Have you or someone 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

Your total score for *all ten* questions indicates the following:

0-7 = sensible drinking

8-15 = hazardous drinking

Would you like information or advice about alcohol consumption?

16-19 = harmful drinking

20+ = possible dependence

Yes No

Do you exercise regularly? Yes No If yes, what exercise do you take and how often:

Data Sharing

We may want to contact you by email, send appointment reminders to your mobile and leave messages on your answering machine, if you have one. **Tick these boxes if you do not wish to be contacted in this way:** Email SMS Answering machine

Summary Care Record (SCR)

The SCR is a summary of your medical history that can be shared between healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information. **More information can be found by visiting www.nhs.uk/summary-care-records**

Tick this box if wish to opt-out of the SCR

Medical Interoperability Gateway (MIG)

Whilst the SCR shares a very small portion of your medical record across the whole NHS, the MIG shares a much fuller view of your records but only with local NHS providers – and only when you give explicit consent at the point of care. **More information can be found on our website.**

Tick this box if you wish to opt-out of the MIG

The Accessible Information Standard (AIS)

Please use this space to tell us about any specific communication needs you have. i.e. needing information in large print or deafblind telephone contact. For further information please visit <https://www.england.nhs.uk/ourwork/accessibleinfo/>

NHS Organ Donor Registration

"I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death". Please tick the boxes that apply.

Any of my organs and tissue or...

Kidneys

Heart

Liver

Corneas

Lungs

Pancreas

For more information, please visit the website www.uktransplant.org.uk or call 0300 123 23 23

Online Patient Access

Once your application to join our practice has been accepted you'll be able to order your repeat medications, book appointments and view certain aspects of your medical record via the internet. This service is known as **Patient Access**.

To register for Patient Access please visit <https://patient.emisaccess.co.uk> to create your account. This service is available to everyone with a valid email address.

We can only accept your request for Patient Access if your email address is valid and not shared by another person.

In accordance with the Data Protection Act, the practice needs consent if you are happy for a 3rd party to collect prescriptions, test results and other medical information on your behalf. Please complete this section if you would like to register a 3rd party.

I give consent for _____ to collect prescriptions on my behalf (Please note that we are unable to hand out prescriptions to anyone under the age of 15)

I give consent for _____ to obtain test results / medical information / appointment information on my behalf (Delete as appropriate)

IT IS YOUR RESPONSIBILITY TO ADVISE US OF ANY CHANGES TO THESE INSTRUCTIONS:

Signed: _____

Date: _____

Once you are registered...

If there are any problems with your registration we'll contact you to clarify any issues, but once your details have been entered into our computerized records...

On-line Services

...You will be able to register with our on-line service provider (EMIS) and access appointments, prescriptions and some sections of your own medical record via the internet. All of the details that you need for this are available on our practice website at www.billesdonsurgery.co.uk on the 'appointments' and 'prescriptions' pages.

New Patient Health-check

...You will be eligible for a new patient health-check with a Practice Nurse/Health Care Assistant. Contact reception if you should like to take this up.

Electronic Prescription Service (EPS)

... you will be able to nominate a pharmacy to collect your prescriptions from. EPS enables prescribers, such as GP's and practice nurses, to send prescriptions electronically to a pharmacy of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff. If you have already nominated a pharmacy, please tell us which pharmacy you have chosen. For further information about this service please talk to your pharmacist of choice.

Please record any additional information about you that you think is important for us to know

***Signed**

***Date** / / /

Signed on behalf of patient (*if applicable*)
(e.g. for minors under 16 years old, adults lacking capacity)

FOR OFFICE USE ONLY

PHOTO ID TYPE: _____ ADDRESS ID TYPE: _____
(Aged 18 and over only)

ID exempt (returning university students only)