Welcome to Firs House Surgery!

Please complete all sheets and hand back to reception when finished, thank you.

Name_____

Preferred means of communication, if required:

Braile Large Print Audiotape Sign Language Written

Home Telephone Number: _____

Mobile Telephone Number: _____

Do you give us permission to send a text message to your mobile? (This will enable us to send you reminders or referral details in the future) ☐ ☐ Yes No

Email Address: _____

By providing an email address we will automatically enter you into our Virtual Patient reference group, this will involve sending you emails no more than 3-4 times a year and sending you our newsletter and the patient satisfaction survey. If you do not wish to participate please tick the box below.

I do not wish to participate in the virtual patient reference group

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Next of Kin _____

Relationship to you _____

Telephone Number for Next of Kin _____

Current medication

List any medication you currently receive from your doctor

Allergies

Please tick the appropriate box to indicate your ethnic group.

A. White

British ☐ Irish ☐ Any other white background (please specify) ……

B. Mixed

White & Black Caribbean ☐ White & Black African ☐ White and Asian

Any other Mixed Background (please Specify)……

C. Asian or Asian British

Indian ☐ Pakistani ☐ Bangladeshi

Any other Asian background (please specify)……

D. Black or Black British

Caribbean ☐ African ☐ Any other Black background (please specify)

……

E. Chinese or other Ethnic Group

Chinese ☐ Any other (please specify)……

Not Stated (please specify)……

Additional Information

Children (under 18 year old)

Religion: _____ First Language: _____ School/nursery attended:_____

Who has the parental responsibility: _____

NHS Health Checks - This only applies to patients aged between **40 – 74** who have no underlying illnesses such as diabetes, heart problems, stroke, and kidney disease.

Have you previously had a health check in the last 3 years? Yes ☐ No ☐

If no, would you like an NHS health check with the nurse? Yes ☐ No ☐

They are completely free and only take 15 minutes. They use a range of information to determine if you are likely to get diabetes, strokes, heart disease, kidney disease and we can then help you if your score comes back high. It is always good to know you are healthy and would only need one every 5 years if you have one.
If possible could you please fill out the information below for the nurses-

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Height: _____cm Weight:_____kg

Family History	Family members & their age at diagnosis		Family Members & their age at diagnosis
Breast Cancer	…….	Ischaemic Heart Disease	…….
Stroke/CVA	……	Gastrointestinal Tract	…….
Asthma	……	Diabetes Mellitus	…….

Other…….

Carers

A carer is someone that looks after a relative, friend or partner who is ill, frail or disabled. We would like to know so we can offer you help with things such as the ICER scheme and the GP carers prescription service.
By filling in this form you agree to us sending your information onto CrossRoads Care so they can contact you.

I have a carer **Carers Name**_____ **Telephone**_____

Relationship to you_____

I am a carer – I would like to receive information about services

Who do you care for? / Relationship _____

Date……. Name……

Online Services

- Basic access – allows you to order repeat prescriptions, book and cancel appointments
- Full Coded Record Access – allows you to see your coded records, immunisations and test results

Please ask a receptionist for the online access forms. You will need two types of ID documents. ich you can get from reception once you have registered and then go onto our website www.firshouse.com and follow the instructions for the online services. You can then order prescriptions and make appointments without coming into the surgery or phoning in! This means there is less strain on the phone lines for people who need to phone in.

Smoking Questionnaire – For all Adults & Children aged 14 and over

Thank you for taking a few moments to fill in the following questionnaire. The information is confidential and will enable us to update our records. Please circle the appropriate answer, or insert the relevant information.

Name_____ **Date of Birth**_____

Section 1

Are you a current smoker? Yes ☐ No ☐ If no, please answer question 2A
If yes, Please go to question 2B

Section 2

2A) Have you ever smoked? Yes ☐ No ☐

If no, thank you for your time.

If yes, please answer questions 2B to 2F.

2B) At what age did you start smoking? _____ Years old

2C) How much did/do you smoke? Less than 1 cigarette per day ☐ 1-9 cigarettes per day ☐
10-19 cigarettes per day ☐ 20-39 cigarettes per day ☐
40+ cigarettes per day ☐

2D) Tobacco (25grams = 1oz) _____ grams per week

2E) Cigars – How many did/do you smoke per day? _____ Cigars per day

2F) when did you stop smoking? _____

3) If you are a current smoker. Have you ever tried giving up? Yes ☐ No ☐

Help can be given to give up smoking. Would you like to see one of our nursing team or be referred to Camquit for smoking cessation advice?

Yes ☐ No ☐

If yes, what is the best way to contact you? _____

Alcohol Users Disorder Identification Test (AUDIT)

Name_____ **Date of Birth**_____

	0 Never	1 Monthly Or less	2 2 – 4 month	3 2 – 3 a week	Your Score per week	
How often do you have a drink that contains alcohol?	☐	☐	☐	☐	☐	
How often do you have 6 or more standard drinks on one occasion?	☐	☐	☐	☐	☐	
How often in the last year have you found you were not able to stop drinking once you had started?	☐	☐	☐	☐	☐	
How often in the last year have you failed to do what was expected of you because of drinking?	☐	☐	☐	☐	☐	
How often in the last year have you needed an alcoholic drink in the morning to get you going?	☐	☐	☐	☐	☐	
How often in the last year have you had a feeling of guilt or regret after drinking?	☐	☐	☐	☐	☐	
How often in the last year have you not been able to remember what happened when drinking the night before?	☐	☐	☐	☐	☐	
	1 – 2	3 – 4	5 – 6	7 – 8	10+	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	☐	☐	☐	☐	☐	
	No		Yes, but Not in last Year		Yes, during last year	
Have you or someone else been injured as a result of your drinking?	☐	☐	☐	☐	☐	
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	☐	☐	☐	☐	☐	

Scoring : 0-7= sensible drinking, 8-15= hazardous drinking, 16-19=harmful drinking and 20+ = possible dependence