THE CLIFT SURGERY

ADULT SUMMARY OF INFORMATION

Please complete all pages in FULL using BLOCK capitals

Surname

First Names (in full)

Previous Surnames

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Male ☐Female

Date of Birth (day/month/year)N

Town & country of Birth

Address

Post Code:

Telephone number: e number:

Email address:

Please be aware that sharing mobile telephone numbers or email addresses may compromise confidentiality. To maintain patient confidentiality we will not knowingly send appointment reminders or clinical information to a shared mobile telephone number or email address. This document will be scanned into, and will become part of,your NHS medical record.

Where you have provided information on how to contact you, can you confirm you are happy for the Clift Surgery to contact you by the following:

By email ☐ Yes ☐No

This will be to send you letters and newsletters, clinical and no clinical relating to the surgery

By text ☐Yes ☐No

If you agree, the mobile number will be used to send appointment reminders of booked medical appointments, invitations to attend clinics and information appropriate to your medical condition.

IN ORDER TO MAINTAIN PATIENT CONFIDENTIALITY WE CANNOT ACCEPT MOBILE TELPHONE NUMBERS OR EMAIL ADDRESSES WHICH ARE SHARED

Do you have any information or communication needs? Eg large print – (these specific needs may be shared with other NHS and adult social care providers when appropriate)

Please tell us about yourself:

Are you a carer? ☐ Yes ☐No
(a carer is anyone who cares for a sick relative or friend) Please ask for a Carers pack

Do you have a carer? ☐ Yes ☐No
If yes, please tell us the name & address of your carer

Are you happy for us to contact your carer about you? ☐ Yes ☐No

Do you have a Private Fostering Arrangement ☐ Yes ☐No

If **yes** please provide further details: ____

Are you a War Veteran? (Please provide proof) ☐ Yes ☐No

Personal Medical History…..

Have you ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below:

Condition	Year diagnosed	Ongoing
		Yes/No
		Yes/No
		Yes/No

Family History…..

Have any close relatives (*father, mother, sister, brother only*) ever suffered from any of the following: (please indicate who in the boxes)

Heart attack Under age 60	Stroke	Diabetes	High blood pressure	Asthma	Glaucoma	Cancer

Allergies ……

Please list any allergies you have to any drugs/medication:

Name of medication	What was the problem or upset?

List of current medication ……

If you have a copy of your repeat medications, please pass to Reception to copy

Name of medication	Dosage

Lifestyle ……

Please enter your height, weight and blood pressure – if you don't know this please use the machine located in the reception foyer.

Height:	Weight:	BP:

Lifestyle smoking ……

Do you smoke? ☐ Yes ☐No

If yes, do you smoke: ☐ Cigarette ☐Cigars ☐Pipe

Are you an ex-smoker? ☐ Yes ☐No

When did you give up? ☐

Are you interested in our Quit Smoking Clinic? ☐ Yes ☐No

Lifestyle alcohol ……

Do you drink alcohol? ☐ Yes ☐No If yes, please answer the following questions:

	0	**1**	**2**	**3**	**4**
How often do you have a drink that contains alcohol ?	Never	Monthly	2-4 times per month	2-3 times per week	4+ times per week

How many standard alcoholic drinks do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-8	10+
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily

Total score: ☐

Ethnicity ……

Please indicate your ethnic origin:

☐ British or mixed British ☐ Irish ☐African ☐ Caribbean ☐ Indian ☐ Pakistani
☐Bangladeshi ☐ Chinese ☐Other (please state): ☐
☐ Decline to state

First language ……

☐

Next of kin ……

Name: ☐ Tel. contact number: ☐

Relationship: ☐

Signature ……

I confirm that the information I have provided is true to the best of my knowledge and that I have been allocated a named GP and informed of this at the point of registration

Named GP: ☐

Signed: ☐ Date: ☐

Signature of patient ☐ Signature on behalf of patient ☐

Staff use only
Emis Number____________________
ID confirmed initials_______________ Photo ID ☐ Address ID ☐No ID available☐
Eligible for dispensing?____