Selborne Road Medical Centre
Pre-registration Health Assessment Form

All information given on this form will be added to your medical record therefore it is important that this form is completed as fully as possible.

Have you previously been registered at the Practice?	Yes	No
Approximate Date Left the Practice		

First Name		**Sex**	Male Female Other
Surname		**Marital Status** (Please Circle One)	Single
Date of Birth			Married
Address			Divorced
			Widowed
			Other
Email Address		**Occupation**	
Home Telephone		**Mobile Telephone**	

The practice provides an automated text message service. This is primarily used to send automated appointment details and communication relating to your individual care. We do not participate in any form of marketing.

Are you happy to receive text messages directly from the Practice?	Yes	No

The NHS **Summary Care Record** (SCR) is an electronic **summary** of key clinical information (including medicines, allergies and adverse reactions) about a patient, sourced from the GP **record**. It is used by authorised healthcare professionals, with the patient's consent, to support their **care** and treatment.
More information is available www.digital.nhs.uk/services/summary-care-records-scr

Do you agree for your information to be included in the Summary Care Record?	Yes	No

Your GPs computer system has two settings to allow you to control how your medical information is shared:

Sharing Out – This controls whether your full GP electronic patient record can be shared with other NHS Care Services where you are treated. Please record your preference:

Please tick: Sharing Out Yes (shared) □ or No (not shared) □

Sharing In – This controls whether you agree for this practice to view information you've agreed to share at other NHS Care Services. Please record your preference:

Please tick: Sharing In Yes (viewable) □ or No (not viewable) □

Do you have any children?			
Name			**Date of Birth**
	M	F	
	M	F	
	M	F	
	M	F	
	M	F	
	M	F	

Your Health			
Height		**Weight**	

Do you take any regular medication? (If possible please supply a print out of your current medication from your previous GP practice)			**Yes**	**No**
Medication	**Dose**	**Medication**	**Dose**	
Do you have any allergies to medication? (Please provide details)			**Yes**	**No**
Allergies:				

Smoking status	Never Smoked	Ex-smoker (Date stopped)	Current Smoker (Cigarettes per day)
As a practice we would like to strongly encourage you and help support you to stop smoking. Smoking causes many long term health problems including heart disease, stroke, cancer and lung disease. We encourage you to make an appointment with the doctor or nurse to discuss quitting. Help can be accessed through the local pharmacies, Stop Smoking Sheffield (tele 0800 068 4490 : website www.sheffieldstopsmoking.org.uk) and the National Quitline (smokefree helpline 0800 022 4332). The doctors are happy to prescribe nicotine replacement and other therapies within the NICE (National Institute of Clinical Excellence) guidelines.			

How much alcohol do you drink per week? A unit is approximately a pub measure (small glass) of normal strength wine, a half pint of lager or beer or a pub measure of spirits.	Units per week
The NHS recommendation of maximum weekly alcohol intake is up to 14 units for both men and women *If you feel that your alcohol intake is in excess of this on a regular basis, the doctor or nurse would be happy to discuss this with you further and provide help and support. There is also support available from SAAS and AA.*	

Medical History (Please provide details of any significant medical problems)

Please Tick		Date	Please Tick		Date
	Heart attack			Asthma	
	Angina			Chronic Lung Disease	
	Stroke or TIA (mini-stroke)			Anxiety or Depression	
	High blood pressure			Mental Health	
	Diabetes (type 1 or type 2)			Dementia	
	Epilepsy			Thyroid disease	
	Kidney disease			Cancer (please provide details)	
	Atrial Fibrillation				

Do you have any other significant health issues?
Please give details
Have you had any significant operations?
Please give details
Please provide any information about vaccinations (with dates if possible)
When was your last cervical smear? (women only)

Family History
Please give details of any significant family illness (including what relationship they are to you)

Carers			
Are you a carer?	**Yes**	**No**	**Please give details of the person you care for:**
Do they live with you?	**Yes**	**No**	
Do you have a carer?	**Yes**	**No**	
Please give details of your carer:			

Patient Ethnic Origin Questionnaire

This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act.

Please indicate your ethnic origin. This is not compulsory, but may help with your health care, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

Choose ONE section from A to E and tick ONE box to indicate your background

A) WHITE		**Please State your first chosen language:**
	British	
	Irish	
	Any other background	Please specify:
B) MIXED		
	White & Black Caribbean	
	White & Black African	
	White and Asian	
	Any other 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) OTHER ETHNIC GROUP		
	Chinese	
	Any other ethnic background	Please specify:
NOT STATED		
	Not stated	

Signed _____ **Date** _____

Please bring this completed form with you in order to register you with the practice