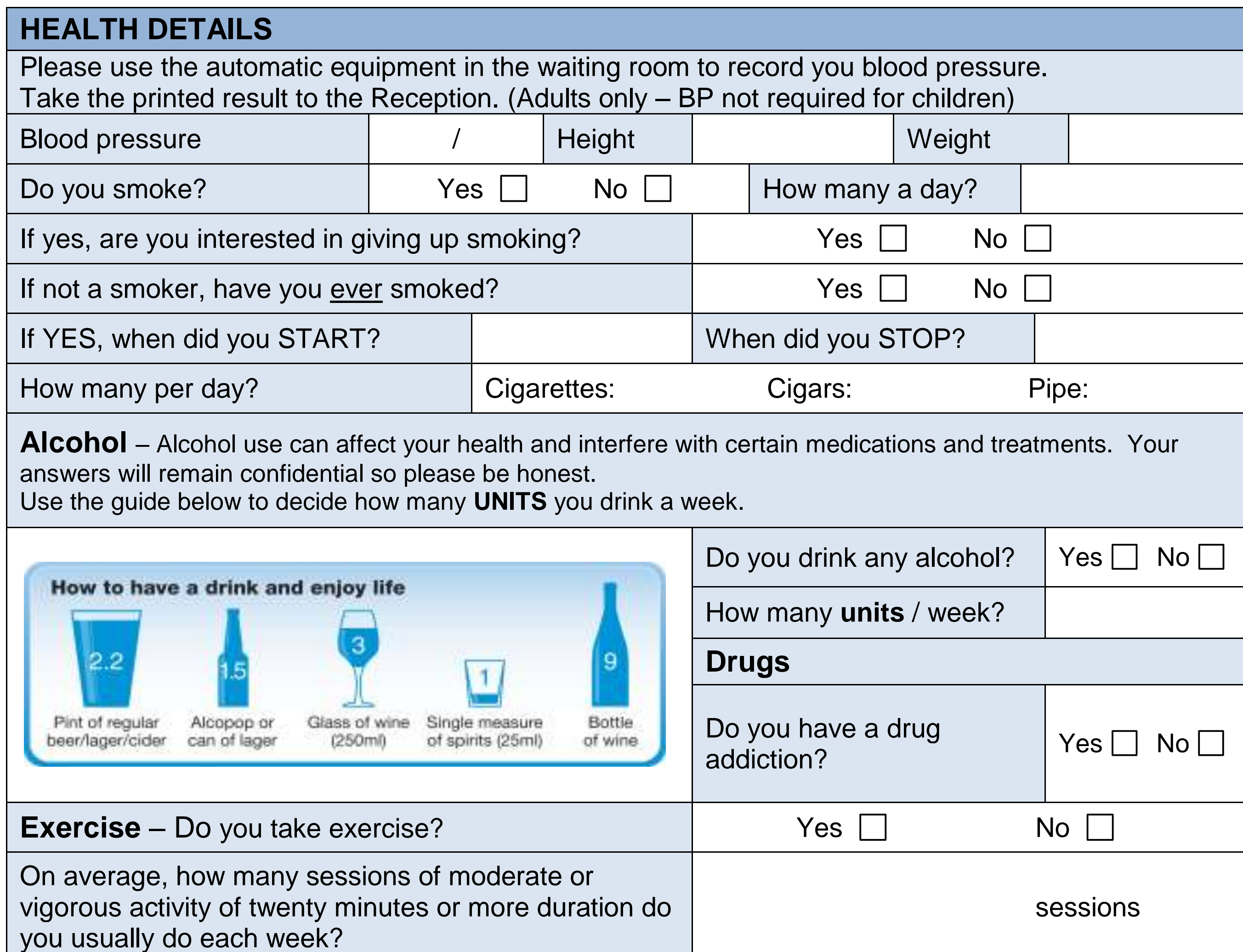
WELCOME TO HIGHFIELD SURGERY

To register with this practice, please complete this questionnaire as fully as possible. It can take some time for your previous medical records to reach us. The information you give in this questionnaire will help us to provide you with good medical care.

PERSONAL DETAILS						
Title	Mr / Mrs / Miss / Ms		Have you been registered here before?			Yes ☐ No ☐
Surname			Previous Name			Male Female
Forename(s)			Address			
Date of Birth						
NHS number						
Home Tel:			Postcode:			
Mobile:			Email:			
Work Tel:			Occupation:			
Name of School (if aged 12-18 years):						
Emergency Contact Name:			Relationship:		Tel:	
Next of Kin:			Relationship:		Tel:	
Status	Single	Married	Separated	Divorced	Widowed	Cohabiting

HEALTH DETAILS					
Please use the automatic equipment in the waiting room to record you blood pressure. Take the printed result to the Reception. (Adults only – BP not required for children)					
Blood pressure	/	Height		Weight	
Do you smoke?	Yes ☐ No ☐		How many a day?		
If yes, are you interested in giving up smoking?		Yes ☐ No ☐			
If not a smoker, have you ever smoked?		Yes ☐ No ☐			
If YES, when did you START?		When did you STOP?			
How many per day?	Cigarettes:	Cigars:	Pipe:		
Alcohol – Alcohol use can affect your health and interfere with certain medications and treatments. Your answers will remain confidential so please be honest. Use the guide below to decide how many **UNITS** you drink a week.					



Do you drink any alcohol?	Yes ☐ No ☐
How many **units** / week?	
Drugs	
Do you have a drug addiction?	Yes ☐ No ☐

Exercise – Do you take exercise?	Yes ☐ No ☐
On average, how many sessions of moderate or vigorous activity of twenty minutes or more duration do you usually do each week?	sessions

MEDICAL HISTORY

Do you have, or have you had, any serious health problems (including operations) or long-term conditions?

	✓	Details	Date (if known)
Asthma			
Cancer			
COPD			
Chronic kidney disease			
Diabetes			
Epilepsy			
Heart attack/disease			
High blood pressure			
High cholesterol			
Osteoporosis			
Stroke			
Mental health problems			
Underactive thyroid			
Circulation problems			
Other serious illness			
Any operations			
Any known allergies	Yes ☐ No ☐ If yes, please list.		
Allergic to:		Type of reaction:	
Allergic to:		Type of reaction:	

REPEAT MEDICATION

Are you on any medicines at present?	Yes ☐ No ☐

If you are on regular medication, please provide a recent printout (less than two months old) of your medication to Reception and we will arrange for the items to be set up on our clinical system.

If you do not have a printout, please ask for a doctor's appointment to discuss this.

Do you take any other over-the-counter medication? If so please list:

ELECTRONIC PRESCRIPTION SERVICE (EPS)

The Electronic Prescription Service (EPS) is an NHS service. You will not have to visit the GP practice to pick up your paper prescriptions. Instead, your GP will send it electronically to your nominated Pharmacy. (An information sheet is included in your new patient pack with full details.)
Please indicate your preference below:

I would like my repeat prescriptions sent electronically to:	Pharmacy Branch
I would prefer to collect my repeat prescriptions from the surgery ☐	

FAMILY MEDICAL HISTORY

Have any of your immediate relatives (brothers/sisters/parents) had any of the following:

	✓	**Details**	**Relationship**	**Date** (if known)
Heart attack or angina before age 60				
Heart attack or angina over age 60				
Asthma				
Diabetes				
Stroke				
Cancer				
Any inherited diseases				

FEMALES ONLY

Date of last cervical smear?		Are you pregnant?	Yes ☐ No ☐
Have you had a hysterectomy?			Yes ☐ No ☐

Contraception – what is your current method of family planning?

None		Coil		Injection	
Contraceptive Pill		Sterilisation		Implant	
Condom		Partner had vasectomy		Hysterectomy	

CARERS

Do you look after an elderly or sick relative or friend?	Yes ☐ No ☐
If YES, please indicate relationship:	
Would you like to be put in touch with the Carers Bucks who can offer practical help and support?	Yes ☐ No ☐

Ethnicity – How would you describe your ethnicity?

White	British	Irish	Other white		
Asian	Asian British	Bangladeshi	Indian	Pakistani	Other Asian
Black	Black British	African	Caribbean	Oher black	
Mixed	Asian & White	Asian & Black	Asian & Caribbean	White African	White Caribbean
Other	Chinese	Japanese	Middle Eastern	Other (please state)	

Country of Birth:			
Do you speak English?	Yes ☐ No ☐	First Language (if not English):	

Appointments – please book the following appointments if applicable

If you have asthma / COPD	Appointment with Respiratory Nurse
If you have diabetes	Appointment with Diabetic Nurse
If you have heart disease	Appointment with Cardiac Nurse
If you want to quit smoking	Appointment with Nurse or Advice Leaflet

SMS TEXT MESSAGING			
Would you like to receive text message appointment reminders and other notices from Highfield Surgery?		Yes ☐ No ☐	
I consent to receiving appointment confirmations, reminders and other notices via text messages and will update the Surgery of any changes to my mobile number.			
Signature		Date	