Spa Surgery
205 High Street
Boston Spa
West Yorkshire
LS23 6PY

To register with our Practice please complete this questionnaire, the information will help the doctors and nurses to make an initial assessment of your health which will assist in your future treatment. **(This form must be completed and signed by a patient who is aged 16 or over)**

Surname:	Forenames:
Date of Birth:	Main Spoken Language:
Preferred Tel. No	NHS Number (If Known):
Email address	SMS Consent (please circle) YES NO
Your preferred Pharmacy:	Please provide a form of ID: ☐ Passport ☐ Driving Licence, ☐ Other Seen By:
Your Ethnicity (please tick one option below)	

Asian or Asian British

- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Chinese
- ☐ Any other Asian background

Black, Black British, Caribbean or African

- ☐ Caribbean
- ☐ African
- ☐ Any other Black, Black British, or Caribbean background

Mixed or multiple ethnic groups

- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian

White

- ☐ British
- ☐ Irish
- ☐ Gypsy or Irish Traveller
- ☐ Roma
- ☐ Any other White background

Other ethnic group

- ☐ Arab
- ☐ Any other ethnic group

Carer Status: **(A Carer is a person looking after or responsible for someone whose health is impaired)**

My Carer is	***I Care for:***
Name	Name
Address	Address
Post Code	Post Code
Tel. No	Tel. No
Relationship to me	Relationship to me:

PREFERRED METHOD OF COMMUNICATION (THE ACCESSIBLE INFORMATION STANDARD)

It is important that you let us know if you have any information or communication needs and how we can meet them. Please tick any of the boxes that are relevant to you:

☐ Interpreter Needed (Spoken) ☐ Interpreter Needed (Sign Language) ☐ Hearing Difficulty ☐ Prefers email

☐ Needs Braille ☐ Large Print needed ☐ Difficulty Reading/Writing ☐ Advocate Needed

☐ Any other information or communication needs

Smoking Status: ☐ Never Smoked ☐ Ex-Smoker ☐ Smoker
If a Current Smoker Cigarette Consumption Per Day:
Would you like help to stop Smoking (Tick Yes or No): ☐ Yes ☐ No

Ladies only:	
Date of your Last Smear test:	Result:
Was the test done at (Circle A or B) - A. Your GP's Surgery B. Somewhere else?	

Access to online records	
I would like access to the following (please tick the items you wish to have access to)	
1. Booking appointments	
2. Requesting repeat prescriptions	
3. Limited access to parts of my medical record	
4. Blood test results	

I agree to my GP practice giving me access to my record online.	**YES/NO**
I agree to use the system in a responsible manner in accordance with all instructions given to me by the practice. If not access may be withdrawn.	**YES/NO**
If I see information which does not relate to me, I will immediately log out and report the matter to the practice as soon as possible	**YES/NO**
I agree that it is my responsibility to keep secures my username and passwords. If I think these have been shared inappropriately I will reset them using the instructions supplied. I am also responsible for keeping safe any information I may print from the record.	**YES/NO**
I agree that my details may be used to contact me about how useful I find the service and whether it could be improved.	**YES/NO**
I understand that online access is granted at the discretion of the practice, taking into account my best interests. I will be informed of any decision to withdraw the service. *Please note, this does not affect your rights of Subject Access under the Data Protection Act.*	**YES/NO**
The practice makes every effort to record information as accurately as possible, however there may be information that you do not feel is correct	
If I notice any inaccuracies with my record, I will inform the practice manager as soon as possible of any errors or omissions.	**YES/NO**
I understand that I may see information on my record that I was unaware of / have forgotten about that could cause distress	**YES/NO**
I understand that as before, I will be informed directly, by the practice, of any test results which require further action. However I understand that I may see these results online before the practice has been able to contact me. This could be while the surgery is closed and there is no one available to discuss them with me	**YES/NO**
I understand that the information may not be a complete record and I should not rely on it for insurance purposes.	**YES/NO**

Alcohol Audit

How Often do you have a drink that contains alcohol	N/A ☐ Never ☐(0) monthly or less ☐ (1) 2-4 times per month ☐ (2) 2-3 Times per Week ☐ (3) 4+Times per Week ☐ (4)
How many units do you have on a typical day when you are drinking alcohol?	N/A ☐ Never ☐ 1-2 Units ☐ (0) 3-4 Units ☐ (1) 5-6 Units ☐ (2) 7-9 Units ☐ (3) 10+ Units ☐ (4)
How often do you have 6 or more standard drinks on one occasion?	N/A ☐ Never ☐(0) monthly or less ☐ (1) 2-4 times per month ☐ (2) 2-3 Times per Week ☐ (3) 4+Times per Week ☐ (4)
How often in the last year have you found you were not able to stop drinking once you started?	N/A ☐ Never ☐(0) monthly or less ☐ (1) 2-4 times per month ☐ (2) 2-3 Times per Week ☐ (3) 4+Times per Week ☐ (4)
How often in the last year have you failed to do what was expected of you because of drinking?	N/A ☐ Never ☐(0) monthly or less ☐ (1) 2-4 times per month ☐ (2) 2-3 Times per Week ☐ (3) 4+Times per Week ☐ (4)
How often in the last year have you needed an alcoholic drink in the morning to get you going?	N/A ☐ Never ☐(0) monthly or less ☐ (1) 2-4 times per month ☐ (2) 2-3 Times per Week ☐ (3) 4+Times per Week ☐ (4)
How often in the last year have you had a feeling of guilt or regret after drinking?	N/A ☐ Never ☐(0) monthly or less ☐ (1) 2-4 times per *month ☐ (2) 2-3 Times per Week ☐ (3) 4+Times per Week ☐ (4)*
How often in the last year have you not been able to remember what happened when drinking the night before?	N/A ☐ Never ☐(0) monthly or less ☐ (1) 2-4 times per month ☐ (2) 2-3 Times per Week ☐ (3) 4+Times per Week ☐ (4)
Have you or someone else been injured as a result of your drinking?	N/A ☐ Never ☐(0) monthly or less ☐ (1) 2-4 times per month ☐ (2) 2-3 Times per Week ☐ (3) 4+Times per Week ☐ (4)
Has a relative/friend/Doctor/Health Worker been concerned about your drinking or advised you to cut down?	N/A ☐ Never ☐(0) monthly or less ☐ (1) 2-4 times per month ☐ (2) 2-3 Times per Week ☐ (3) 4+Times per Week ☐ (4)

Scoring: 0-7=Sensible Drinking 8-15=Hazardous Drinking 16-20 Harmful Drinking 20+= Possible Dependence

Current medication: (please attach a current repeat list) Any prescribed medicine, please make an appointment with our pharmacist	**Any Known Allergies**:

Do you suffer from any of the following conditions?
☐ Asthma ☐ COPD ☐ Diabetes ☐ Epilepsy ☐ High blood pressure ☐ Thyroid disease ☐ Heart disease

BP readings (Blood pressure machine in reception): _____/_____ _____/_____	Height: Weight:

Patient signature_____ Date _____

Online access Password:

- ☐ Given in person
- ☐ Sent via SMS
- ☐ Sent by email