Medication and Medical Certificates

Please obtain 6 weeks supply of your medication from your previous GP Practice before registering with us. Our Doctors cannot supply medication without your records from your previous GP Practice or Letters from Hospital.

Please book an appointment with a GP, once registered, with information regarding your medication to obtain a new prescription from us at least 2 weeks before you run out.

Please obtain a new medical certificate from your old GP Surgery, to last at least 4 weeks, if still needed.

The Links Medical Practice

WELCOME TO THE LINKS MEDICAL PRACTICE

Proof of ID:
Passport ☐ Photo driving licence ☐ Birth certificate ☐
Other ☐ .....

Proof of current address (eg utility bill etc – please note down what type of proof)

1. .....

2. .....

Date Received ..... **Accepted by**.....
Must be signed by staff accepting forms

Today's date.....
Please would you complete as much of this form as you can. This is an important part of the registration process and will help us to provide better medical care for you. Thank You.

PLEASE MAKE SURE THAT YOU FILL IN ALL INFORMATION THAT IS IN BOLD PRIOR TO HANDING THIS DOCUMENT INTO RECEPTION!

SURNAME..... **FIRST NAME(S)**.....

ADDRESS.....

..... **POST CODE**.....

MAIDEN NAME (if applicable).....

TEL NO HOME.....
WORK.....
MOBILE.....
EMAIL.....

Can your mobile number be used to text you re appointments if needed: Yes ☐ No ☐
Can your email address be used to communicate with you if needed: Yes ☐ No ☐

SEX : Male ☐ Female ☐ **DATE OF BIRTH**.....

Are you a Carer: YES ☐ NO ☐
(A carer is someone who without payment, provides help and support to a partner, child, parent, relative, friend or neighbour, who could not manage without your help)

PREVIOUS GP NAME & ADDRESS.....

.....

ETHNIC ORIGIN: Please complete attached document

SPOKEN LANGUAGE: Please **complete attached document.**

MARITAL STATUS
Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Cohabiting ☐

Partner's Name.....

Your Occupation..... Are You a Carer Yes ☐ No ☐

WHO LIVES IN THE HOUSEHOLD WITH YOU?
Full Name Age Relationship to you e.g. Son, Wife etc
1.
2.
3.
4.

Next of Kin Name and relationship (e.g mother) .....

Next of Kin contact telephone number.....

SMOKING - Are you a non-smoker? ☐ A current smoker? ☐

If a current smoker, do you smoke (please delete as appropriate)

Cigarettes/ Cigars: **How many a day.:**

Pipe/ Roll ups: **How much tobacco a week?**

ALCOHOL - Do you drink alcohol? No ☐ Yes ☐
(Please complete separate sheet attached (audit C))

DIET – Is your diet: Vegetarian? ☐ Vegan? ☐ Egg Free? ☐

Milk Free? ☐ Low Fat? ☐ High Fibre? ☐

Other Please State.....

EXERCISE – please tick one of the following:

Avoid Exercise ☐ Enjoy Light Exercise ☐ Moderate Exercise ☐

Enjoy Heavy Exercise ☐ Competitive Athlete ☐

Other, Please State .....

FAMILY HISTORY

Have you or a member of your direct family (brothers, sister, parents, children) ever suffered from:

	Self	Family Member Age at Onset (Please state which member)
Heart Disease If before age 60	☐	☐
Heart Disease If after the age of 60	☐	☐
Angina	☐	☐
Stroke	☐	☐
Breast Cancer	☐	☐
Lung Cancer	☐	☐
Skin Cancer	☐	☐
Leukaemia	☐	☐
Bowel Cancer	☐	☐
Cervical/Ovary/ Womb Cancer	☐	☐
Other Cancer State Type	☐	☐
Diabetes	☐	☐
Asthma	☐	☐
Eczema	☐	☐
Hay Fever	☐	☐

High Blood Pressure (Hypertension)	☐	☐
Depression	☐	☐
Mental Illness	☐	☐
Glaucoma/ Blindness	☐	☐
Epilepsy/Fits	☐	☐
Multiple Sclerosis	☐	☐
Alzheimer's Disease	☐	☐
Sickle Cell & Thalassaemia	☐	☐
Thrombosis	☐	☐

Any Unusual illness in your family.....

MEDICAL HISTORY

Please list any operation, hospital admission or serious illness you have had, or have at present

Date.	Details	Treatment	Outcome	Duration and time of work
1.				
2.				

Do you take any medication or inhalers? No ☐ Yes ☐

If yes, please list names.....

.....

.....

.....

What medications are you allergic to?.....

What other allergies/bad reactions to medications do you ave?.....

When did you have your last tetanus injection?.....

Have you had a Pneumonia Injection? No ☐ Yes ☐

WOMEN ONLY

Have you had any pregnancies? No ☐ Yes ☐

Please give dates	Male	Female	Normal Delivery	Caesarean	Forceps/ Ventouse	Term (Week)
.....	☐	☐	☐	☐	☐	☐
.....	☐	☐	☐	☐	☐	☐
.....	☐	☐	☐	☐	☐	☐
.....	☐	☐	☐	☐	☐	☐

Have you had any miscarriages? No ☐ Yes ☐

If yes please give Details.....

Have you had any terminations? No ☐ Yes ☐

If yes please give details.....

Do you use any form of contraception? No ☐ Yes ☐ Not Applicable ☐

If yes state what.....

Have you had a cervical smear test? No ☐ Yes ☐

If yes date of last test.....

Place of last test.....

Result.....

Have you had a hysterectomy? No ☐ Yes ☐
If yes total or subtotal?

Date of hysterectomy.....

Thank you for taking the time to complete this questionnaire.

Please note if you need any help completing these please ask a member of staff for help.

Standard Tick Box for recording ethnic group

What is your ethnic group?

*Please choose **ONE** section from A to E, then tick the appropriate box on the right to indicate your ethnic group.*
Thank you.

Ethnic Group	**TICK HERE**	
A White British		9i0
Irish		9i1
Any other white background (please write in line below)		9i2
B Mixed White and Black Caribbean		9i3
White and Black African		9i4
White and Asian		9i5
Any other mixed background (please write in line below)		9i6
C Asian or Asian British Indian		9i7
Pakistani		9i8
Bangladeshi		9i9
Any other Asian background (please write in line below)		9iA
D Black or Black British Caribbean		9iB
African		9iC
Any other Black background (please write in line below)		9iD
E Chinese or other ethnic group Chinese		9iE
Any other (please write in line below)		9iFK
Not stated/declined Declined: patient chooses not supply this information		9SD

NHS
Bromley

FIRST LANGUAGE TICK BOX RECORDING

Please tick the box that applies to the main language that you/the patient speaks or prefers to speak.

Language	Tick Box	Read Code
Akan (Ashanti)		13lc.
Albanian		13lS.
Amharic		13ld.
Arabic		13l0.
Bengali		13l1.
Brawa		13le.
Uses British Sign Language		**13ZM**
Cantonese		13l2.
Creole		13Z6
Dutch		13lf.
English		13l4.
Ethiopian		13lg.
Farsi (Persian)		13lO.
Finnish		13uT.
Flemish		13lh.
French		13l5.
French Creole		13li.
Gaelic		13lj.
German		13lR.
Greek		13lV.
Gujerati		13l6.
Hakka		13lk.
Hausa		13l7.
Hebrew		13ll.
Hindi		13l8.
Igbo		13lm.
Italian		13lQ.
Japanese		13lW.
Korean		13lX.
Kurdish		13lN.
Lingala		13ln.
Luganda		13lo.
Makaton Sign Language		**13ZP**
Malayalam		13lp.
Mandarin		13lB.
Norwegian		13lq.
Pashto (Pushtoo)		13lr.
Patois		13ls.
Polish		13lC.
Portuguese		13lD.
Punjabi		13lE.
Russian		13lF.
Serbian		13lt.
Croatian		13lT.
Sinhala		13lu.
Somali		13lG.
Spanish		13lH.
Swahili		13lI.
Swedish		13lv.
Sylheti		13lJ.
Tagalog (Filipino)		13lw.
Tamil		13lK.
Thai		13lx.
Tigrinya		13ly.
Turkish		13lZ.
Urdu		13lL.
Vietnamese		13lb.
Welsh		13lz.
Yoruba		13lM.
Other		**13Z6**
Patient Declines		**13ZG**

The Fast Alcohol Screening Test (FAST)

YOUR NAME.....

This quick questionnaire will help you assess your drinking habits and will help us to provide you with better care. The questionnaire is confidential and you are under no obligation to answer it.

Please circle the answer that best applies to you:

1 Unit = ½ pint of beer / one ordinary sized glass of wine / one measure of spirits

	SCORE

	0	1	2	3	4
How often do you have an alcoholic drink	Never – if this applies to you, do not answer any more question	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week
How often have you had 8 or more units if male, or 6 or more units if female, on a single occasion the past year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the past year have you been unable to remember what happened the night before because your have been drinking	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the past year have you failed to do what was normally expected of you because of drink?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
In the past year have any relatives, friends, doctors or other health workers expressed concern about your drinking or suggest you cut down			Yes once		Yes more than one occasion

Thank you for your time, we will use the results to provide you with personalised care and to improve the running of our practice

TOTAL SCORE