Castle Medical Group

www.castlemedicalgroup.co.uk

118 Burton Road
Ashby de la Zouch
Leicestershire
LE65 2LP

T: 01530 414131
F: 01530 560732

PLEASE ALLOW AT LEAST 7 WORKING DAYS FOR THE REGISTRATION TEAM TO DEAL WITH YOUR REGISTRATION BEFORE YOU TRY TO BOOK AN APPOINTMENT.

Thank you for applying to join Castle Medical Group. We would like to gather some information about you and ask that you fill in the following questionnaire. You don't have to supply answers to all of the questions but what you do fill in will help us give you the best possible care. **You must supply TWO forms of Identification with your completed form, a photographic form of ID (such as a PASSPORT or DRIVING LICENCE) and proof of your home address (such as a recent BANK STATEMENT or UTILITY BILL that is less than 3 months old).**

Please complete all areas in **CAPITAL LETTERS** and tick the appropriate boxes. Please ensure you **SIGN** and **DATE** your form.
Fields marked with an asterix (*) are mandatory.

*Title *Surname	*First names
*Any previous surname(s) (if applicable)	*Date of Birth
* ☐ Male ☐ Female	***NHS No** ☐☐☐☐☐☐☐☐☐☐
Town and country of birth	*Home address
*Home telephone No	*Postcode
Work telephone No	Email address
*Mobile No (if you have one)	

Your previous address

*Previous address in the UK (if applicable) Postcode

Previous doctor's details

Name of previous doctor
Address of previous doctor

If you are from abroad

*Your first UK address where you registered with a GP if you were previously living abroad Postcode	*If previously a resident in the UK, date of leaving
	*Date you first came to live in the UK (if applicable)

Tick this box if you have you ever been in the employ of the Armed Forces ☐

If you are returning from the Armed Forces

Address before enlisting Postcode	Service or Personnel No.
	Enlistment date Leaving Date

Additional details about you

What is your ethnic group? Marital Status:

White	☐ British	☐ Irish	☐ Other White (please specify):	
Black	☐ Caribbean	☐ African	☐ Other Black (please specify):	
Asian	☐ Indian	☐ Pakistani	☐ Other Asian (please specify):	
Mixed	☐ White & Black Caribbean		☐ White & African	☐ White & Asian

Height	ft	in
Weight	st	lb
Waist measurement	in	

(**for women only**) Have you had a cervical smear?
☐ Yes ☐ No (*Please state where, when and the result if possible*)

Carer

Do you have a Carer or does someone help to look after you? ☐ Yes ☐ No
If yes, please collect a Carer's Pack from the Main Reception.

Are you a Carer or do you look after someone on a regular basis? ☐ Yes ☐ No
If yes, please collect a Carer's Pack from the Main Reception.

Looked after Children

Are you looking after someone else's child? ☐ Yes ☐ No
If Yes, under what arrangements:
Section 20-Voluntary Care/ Interim Care Order/ Care Order
Child arrangement order/Residence Order/ Special Guardianship Order/ Placed for adoption/
Private arrangement/Private Fostering/informal arrangement
(please note you have a duty to notify social care of this arrangement)

If you are applying on behalf of a child who is in foster care/residential care/Kinship care/ or who is not your child

Who has the legal responsibility for the child?

You as the legal parent or guardian

Other (please specify)

_____

Who can consent for the medical treatment for the child?

You as the legal parent or guardian

Other (please specify)

_____

Next of kin

Name of next of kin	Relationship to you
Next of kin telephone number(s)	Next of kin address (if different to above)

Medication

Are you taking any prescribed medication? Yes ☐ No ☐

If yes, we have the facility to prescribe your medication electronically to a nominated pharmacy, i.e. we do not issue you with a paper prescription and the 48 hour turnaround is the same.

The following are the local pharmacies :– Boots ☐ Dean & Smedley ☐ Ashby Pharmacy ☐ Tesco Pharmacy ☐

Please tick your preferred pharmacy

In order to continue to receive your repeat medications you'll need to make an appointment with a GP at least one week before your next prescription is due.

*Are you allergic to any medicines? ☐ Yes ☐ No (if yes please specify)

*List other allergies (pollen, animal hair or certain foods. Please mark "none" if you have no other allergies that you know of)

Have you ever had any of the following conditions?

Epilepsy	☐ Yes	Year	**Rheumatoid Arthritis**	☐ Yes	Year
High Blood Pressure	☐ Yes	Year	**Mental Illness (inc Depression)**	☐ Yes	Year
Heart Attack	☐ Yes	Year	**Diabetes (type 1 or type 2)**	☐ Yes	Year
Angina (stable / unstable)	☐ Yes	Year	**Asthma**	☐ Yes	Year
Stroke	☐ Yes	Year	**COPD (or Emphysema)**	☐ Yes	Year
Transient Ischaemic Attack	☐ Yes	Year	**Osteoporosis / Bone Fractures**	☐ Yes	Year
Cancer	☐ Yes	Year	**Peripheral Vascular Disease**	☐ Yes	Year

List any serious illnesses / operations / accidents / disabilities (women: any pregnancy related problems) & the year they took place

Do you have family history of any of the following?

High Blood Pressure	☐ Yes	Who	**DVT / Pulmonary Embolism**	☐ Yes	Who
Ischaemic Heart Disease Diagnosed aged >60 yrs	☐ Yes	Who	**Breast Cancer**	☐ Yes	Who
Ischaemic Heart Disease Diagnosed aged <60 yrs	☐ Yes	Who	**Any Cancer** Specify type:	☐ Yes	Who
Raised Cholesterol	☐ Yes	Who	**Thyroid disorder**	☐ Yes	Who
Stroke / CVA	☐ Yes	Who	**Epilepsy**	☐ Yes	Who
Asthma	☐ Yes	Who	**Osteoporosis**	☐ Yes	Who

Please tell us about your smoking habits

Do you smoke? ☐ Yes ☐ No

If Yes, what do you primarily smoke:
Cigarettes / Cigar / Pipe **(please circle)**

If you would like smoking cessation advice, please contact Quit Ready Leicestershire at www.quitready.co.uk or by phone on 0345 646 6666.

How many do you smoke a day?

Would you like advice on quitting? ☐ Yes ☐ No

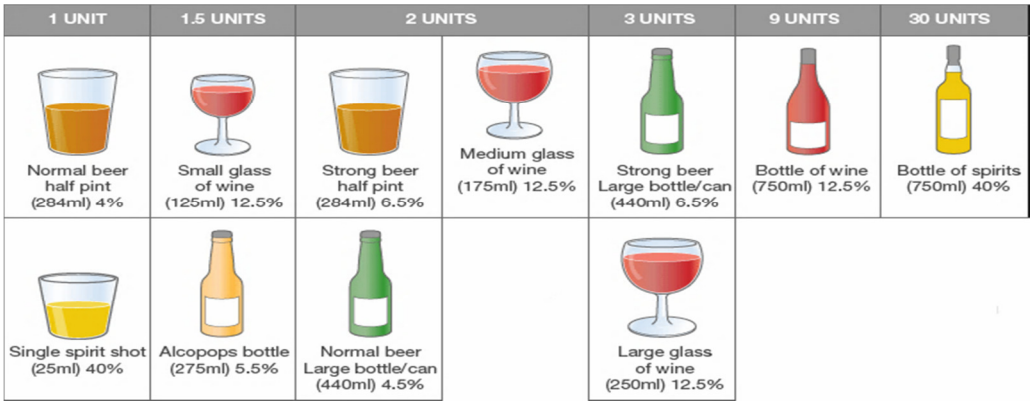
Are you an ex-smoker ☐ Yes ☐ No
When did you quit?

How many did you smoke a day?

Please tell us about your alcohol consumption

Questions (please circle your answers in the boxes below)	**Unit scoring system**				
	0	**1**	**2**	**3**	**4**
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times Per month	2 - 4 times per week	4+ times per week
How many units of alcohol do you drink on a typical day when you are drinking?	1 - 2	3 – 4	5 – 6	7 – 9	10+
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

If your unit score is higher than 5 units, please ask for additional Alcohol Questionnaire at the Main Reception.



Data Sharing

Summary Care Record (SCR)
The SCR is a summary of your medical history that can be shared between healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information. **More information can be found by visiting www.nhscarerecords.nhs.uk**

Patients Summary Care Record (SCR) Consent Preference:
-Express consent for medication, allergies, adverse reactions and additional information ☐ Yes ☐ No
-Express dissent – patient does not want a Summary Care Record
☐ Yes ☐ No

NHS Organ Donor Registration
"I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death". Please tick the boxes that apply.

☐ Any of my organs and tissue or…
☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

Signature confirming my agreement to organ/tissue donation ……. ***Date……/……./……..***
For more information, please visit the website *www.uktransplant.org.uk* or call 0300 123 23 23

NHS Blood Donor Registration
"I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood."
Tick here if you have given blood in the last 3 years ☐

Signature confirming consent to inclusion on the NHS Blood Donor Register …… ***Date……/……./…….***

Please record any additional information about you that you think is important for us to know

SystmOnline

Once your application to join our practice has been accepted you'll be able to order your repeat medications, book appointments and view certain aspects of your medical record via the internet. This service is known as **SystmOnline**.
Once you are a fully registered patient of our practice you can obtain a User ID and Password from Reception.

***Signed**

***Date / / /**

Signed on behalf of patient (*if applicable*)
(e.g. for minors under 16 years old, adults lacking capacity)

FOR OFFICE USE ONLY

PHOTO ID ☐ **TYPE: _____** **ADDRESS ID** ☐ **TYPE: _____**
(Aged 16 and over only)

Change of Name Deed Poll ☐ **Marriage Certificate** ☐

Overseas Patients:
Non UK EHIC ☐ **or PRC** ☐ **and S1 Forms** ☐