Welcome to Broomhill & Lodge Moor Surgeries

Pre-registration Health Assessment Form

Personal Details. 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? No ☐ Yes ☐

Date left ……………………

Do you wish your summary care records to be uploaded to the National Spine? No ☐ Yes ☐
This will only involve uploading medication and any allergies you may have.

Surname ………………………………………………… Date of Birth …………………………………

Forename(s) …………………………………………………

Address …………………………………………………

…………………………………………………

…………………………………………………

email address …………………………………………………
(please print for clarity)

Are you?
Tick as appropriate

☐ Single
☐ Married
☐ Separated
☐ Divorced
☐ Widowed
☐ Other

Home telephone ………………………………………………… Mobile …………………………………………………

Occupation ………………………………………………… Sex male ☐ female ☐ other ☐

If you have children, please give their details below:-

Name	Gender	Date of Birth
…………………………………………………………	M F	………………………………
…………………………………………………………	M F	………………………………
…………………………………………………………	M F	………………………………
…………………………………………………………	M F	………………………………

Your Health

What is your approximate height? …………………… **What is your approximate weight?** ……………………

Do you take routine medication? ☐ No ☐ Yes
e.g. oral contraception, blood pressure tablets etc.

If yes, please give details: Drug name ……………………………………………… dose ……………………… daily ……………………

……………………………………………… dose……………………… daily…………………

……………………………………………… dose ……………………… daily …………………

Are you allergic to any medication? ☐ No **If yes, what & what reaction?**……………………………………………………………

e.g. penicillin

Pre-registration Health Assessment Form (cont.2)

Do you drink? ☐ No

☐ Yes

If yes, how much? .... units 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.

The NHS recommendation of maximum weekly alcohol intake is up to 14 units for a female and up to 21 units for a male.

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.

Smoking status ☐ never smoked

☐ ex-smoker - amount previously smoked per day .... year of quitting ....

☐ current smoker – amount smoked 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.

FEMALES ONLY

Have you had a Cervical Smear test ? ☐ Yes (please give date) ....

Where ....

Females aged 25-50 years are advised to have a cervical smear test every three years.
Females aged 50-65 years are advised to have a cervical smear test every five years.

Medical History

Have you ever suffered from the following?

Condition (Tick as appropriate)	What year(s)?	Condition (Tick as appropriate)	What year(s)?
☐ Heart attack	....	☐ Thyroid disorder	....
☐ Angina	....	☐ Cancer	....
☐ Stroke/TIA (mini-stroke)	....	☐ Asthma	....
☐ High Blood pressure	....	☐ Depression	....
☐ Diabetes	....	☐ Mental Health Problems	....
☐ Chronic bronchitis	....	☐ Dementia	....
☐ Epilepsy	....	☐ Atrial Fibrillation	....
☐ Kidney disease	....		

Please give details of any operations you have undergone (Please specify and give approximate year).

....

....

....

Have you had any other significant illnesses? (Please specify and give approximate year).

....

Pre-registration Health Assessment Form (cont.3)

Please provide us with your recent vaccination history:- ....

....

....

....

Carers

Are you a carer? ☐ No ☐ Yes

If Yes, for whom do you care (please supply details)

Is this person registered here? ☐ No ☐ Yes

....

Do you have a carer? ☐ No ☐ Yes

....

Please provide details of your carer:

Name ....

Address ....

Contact Number..

....

Family History

Please provide us with information on the general health of your family

Your parents	Age	State of health	**Your brothers and /or sisters**	Age	State of health
Father	....	....	M F	....	....
Mother	....	....	M F	....	....
			M F	....	....
			M F	....	....

Are there any family illnesses? If so, please give details e.g. heart problems, diabetes etc.

....

....

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

PLEASE STATE YOUR FIRST SPOKEN LANGUAGE:-......................................

A) WHITE

British ☐

Irish ☐

Any other background ☐ Please specify [ ]

Pre-registration Health Assessment Form (cont.4)

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