Affinity Care Registration Form

Cowgill Surgery, Haigh Hall Medical Practice, North Street Surgery,
Shipley Medical Practice, Sunnybank Medical Practice, Thornton & Denholme and The Willows

Patient Details	
Name:	**Date of Birth:**
Home Telephone Number:	
Mobile Telephone Number:	
Email Address:	
Next of Kin	
Name:	**Relationship:**
Next of Kin Address and Telephone Number:	

Do you consent to the practice contacting you by text or email message for the purposes of health promotion and for appointment reminders? ☐ Yes ☐ No

Would you like to register for online access? ☐ Yes ☐ No
This allows you to book / cancel appointments, order medication, view your record, etc. If you have ticked "Yes" we will send you a link to the NHS app, which we recommend for online access. If you are unable to download apps / need assistance, please speak to our receptionists.

Are you interested in joining our patient participation group? ☐ Yes ☐ No
This group meets every 2 months to allow patients to have a say in how we can provide the best care for them.

If yes, do you consent to us sharing your email address with the chair of the patient participation group so that she can provide you with further details? ☐ Yes ☐ No

Do you consent to share your medical records with authorised healthcare staff like emergency departments so that they are better equipped to treat you safely and effectively? ☐ Yes ☐ No

Do you consent for this practice to view medical information that you've agreed to share at other NHS care services? ☐ Yes ☐ No

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Gender and Sexual Orientation	
☐ Heterosexual / Straight	☐ Bisexual
☐ Lesbian / Gay	
Which of the following best describes you?	
☐ Female	
☐ Male	
☐ Non-Binary	
Is your gender identity the same as the gender you were given at birth?	
☐ Yes	☐ No
What pronoun/s do you use?	

Please use our self-service machine to measure your BP and Pulse Rate

Measurements			
Height		**Weight**	
BP		**Pulse rate**	

Smoking			
Do you smoke?	☐ Current Smoker	☐ Ex-smoker	☐ Never Smoked
Are you interested in our stop smoking clinic?		☐ Yes	☐ No
Are there any smokers in the household?		☐ Yes	☐ No

Exercise			
In an average week how often do you exercise? Note: Twenty minutes of vigorous walking counts as one exercise session.			
☐ Never	☐ 1-2 times each week	☐ 3-4 times each week	☐ 5-7 times each week

Armed Forces	
Have you ever been in the armed forces?	☐ Yes ☐ No

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Alcohol				
How often do you have a drink that contains alcohol?				
☐ Never	☐ Monthly or less	☐ 2-4 times per month	☐ 2-3 times per week	☐ 4+times per week
How many standard alcoholic drinks do you have on a typical day when you are drinking?				
☐ 1-2	☐ 3-4	☐ 5-6	☐ 7-8	☐ 10+
How often do you have 6 or more standard drinks on one occasion?				
☐ Never	☐ Less than monthly	☐ Monthly	☐ Weekly	☐ Daily or almost Daily
How often in the last year have you found you were not able to stop drinking?				
☐ Never	☐ Less than monthly	☐ Monthly	☐ Weekly	☐ Daily or almost Daily
How often in the last year have you failed to do what was expected of you because of drinking?				
☐ Never	☐ Less than monthly	☐ Monthly	☐ Weekly	☐ Daily or almost Daily
How often in the last year have you needed an alcoholic drink in the morning to get you going?				
☐ Never	☐ Less than monthly	☐ Monthly	☐ Weekly	☐ Daily or almost Daily
How often in the last year have you had a feeling of guilt or regret after drinking?				
☐ Never	☐ Less than monthly	☐ Monthly	☐ Weekly	☐ Daily or almost Daily
How often in the last year have you not been able to remember what happened when drinking the night before?				
☐ Never	☐ Less than monthly	☐ Monthly	☐ Weekly	☐ Daily or almost Daily
Have you or someone else been injured as a result of your drinking?				
☐ No	☐ Yes, but not in the last year		☐ Yes during the last year	
Has a relative/friend/ doctor/ health worker been concerned about your drinking or advised you to cut down?				
☐ No	☐ Yes, but not in the last year		☐ Yes during the last year	

Further support for alcohol dependence is available from the surgery or from our local alcohol service (Change,Grow, Live : Tel 01274 296023)

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Medical Information							
Have you suffered from any of the following?							
Epilepsy	☐	**Yes**	☐ **No**	**Diabetes**	☐	**Yes**	☐ **No**
High Blood Pressure	☐	**Yes**	☐ **No**	**Asthma / Breathing Problems**	☐	**Yes**	☐ **No**
Heart Attack / Angina	☐	**Yes**	☐ **No**	**COPD**	☐	**Yes**	☐ **No**
Stroke	☐	**Yes**	☐ **No**	**Thyroid Problems**	☐	**Yes**	☐ **No**
Kidney Disease	☐	**Yes**	☐ **No**	**Mental Health Problem**	☐	**Yes**	☐ **No**
Cancer	☐	**Yes**	☐ **No**	**Dementia**	☐	**Yes**	☐ **No**

Is there anyone in your close family (e.g. parents, brothers, sisters) that has suffered from any of the above?

If so, please specify ……

Do you have a pacemaker? ☐ **Yes** ☐ **No**

Are you under the care of a hospital specialist at present? ☐ **Yes** ☐ **No**
If yes, please give name of specialist hospital and diagnosis:

Are you currently pregnant? ☐ **Yes** ☐ **No**

If yes, when is your expected date of delivery?

Medication	
Please list any medications being taken and the amount: **(or attach repeat prescription from previous GP)**	
Name of Medication:	**Dosage:**

Do you have any allergies or reactions? ☐ **Yes** ☐ **No**
(e.g. to eggs, medicines, vaccinations, medical dressings or foodstuffs)

If yes please provide details:

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Nominated Pharmacy	
Would you like to nominate a local pharmacy where we can send your prescriptions?	
Name of Pharmacy:	

Carers

Do you have a carer? ☐ **Yes** ☐ **No**

If yes, please give details:

If yes, do you give permission for us to discuss your medical needs with your carer?

☐ **Yes** ☐ **No**

Are you an unpaid carer? ☐ **Yes** ☐ **No**

If yes, who do you care for?

☐ **Spouse** ☐ **Relative** ☐ **Neighbour** ☐ **Friend**

Language Requirements

What is your preferred spoken language:

Do you require an interpreter? ☐ **Yes** ☐ **No**

Disabilities and other needs

It is important for us to identify and log a patient's requirements in their medical notes if they have a recorded disability.

Blind	☐ **Yes**	☐ **No**	**Visual Impairment**	☐ **Yes**	☐ **No**
Partially Sighted	☐ **Yes**	☐ **No**	**Hearing Difficulties**	☐ **Yes**	☐ **No**
Deaf	☐ **Yes**	☐ **No**	**Use of Hearing Aids**	☐ **Yes**	☐ **No**
Deaf / Blind	☐ **Yes**	☐ **No**	**Other:**		
Learning Disability	☐ **Yes**	☐ **No**			

Do you have any communication/information needs relating to a disability or sensory loss and if so what they are? For example, letters printed in size 28 plus font.

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Patient Ethnic Group Information

This practice, in line with other healthcare providers, collects information about the ethnic group that patients feel they belong to. You do not have to complete this form but if you do you will be helping us to help you. It will help us plan to deliver better services to our patients and ensure that everyone has equal access to the health care we provide.

All the information that we receive will be used and treated with the strictest confidence in the same way as other information that we hold. When used in the planning of services all names and other identifying details will be removed.

Providing the following information is optional:

Ethnicity		
White	**Asian or Asian British**	**Mixed**
☐ British	☐ Indian	☐ White & Black Caribbean
☐ Irish	☐ Pakistani	☐ White & Black African
☐ Other	☐ Bangladeshi	☐ White & Asian
	☐ Other	☐ Other
Black or Black British		
☐ Caribbean	**Other Ethnic Group**	
☐ African	☐ Chinese	
☐ Other	☐ Other	