

# THE BROMLEY COMMON PRACTICE



Dr C Sriwardhana  
(Partner)  
Dr V Singh (Partner)

Dr S Wijayatilake  
(Partner)  
Anne Said  
(Practice Nurse)

Dr P Kulkarni  
(Partner)  
Kimberley Townsend  
(Practice Nurse)

Debbie Salter  
(Health Care Assistant)

Rosie Yerlett  
(Practice Nurse)

## **CONFIDENTIAL HEALTH QUESTIONNAIRE**

Welcome to The Bromley Common Practice. Please help us by completing this questionnaire, as it may take some time for your medical records to reach us from your previous GP. The information you give will be used to provide you with good medical care. Please note you will **NOT** be registered if this questionnaire is not fully completed. All adults over the age of 16 years must personally submit their registration forms. Our website address is <https://thebromleycommonpractice.co.uk/>

### **PLEASE BRING THE FOLLOWING TO SURGERY WHEN REGISTERING:**

Identification (e.g. passport, driving licence, student card, credit or debit card)

Children under 5 years- Healthcare record/Red book

*If you have difficulty providing identification, please speak to the Receptionist.*

#### ***Office Use Only***

M8 Machine (BP, height, weight etc.)

Red Book seen (under 5 years)

Staff initials

☐

Informed of Named GP

☐

Medication list

☐
☐
☐

### **PLEASE COMPLETE IN BLACK INK**

**Full Name:** .....

.....

**Date of Birth:** .....

**Home No:** .....

**Mob No:** .....

**NHS No:** .....

**Occupation:** .....

*(if under 16 years of age, please leave blank)*

**Next of Kin:** .....

.....

**Next of Kin contact telephone number:**

.....

I agree I may be contacted via text message for appointment reminders and practice news about my health. ☐

I agree I may be contacted via text message for test results and any information regarding my medical health ☐

#### **PATIENT ACCESS**

We will email you login details to register with 'Patient Access'. This enables you to book doctors' appointments, check medication and order repeat prescriptions on-line. It is the patient's responsibility to notify the surgery of any changes to their contact details.

**Email Address:**













.....

<b>Relationship to Next of Kin:</b>  	<b>PHARMACY NOMINATION</b> Please give details of pharmacy for which prescriptions can be sent electronically  
Permission to discuss medical details with next of kin; <span style="float: right; background-color: #d3d3d3; padding: 2px 10px;"><b>Yes</b>   <b>No</b></span> Any other family members at The Bromley Common Practice? <span style="float: right; background-color: #d3d3d3; padding: 2px 10px;"><b>Yes</b>   <b>No</b></span> <b>Please provide full name(s) if family name is different:</b>  	
<b>CHILD REGISTRATION ONLY</b>  <b>School Attended</b> .....  (1). Parent/Guardian Details: Name: ..... Address: .....  Relationship: ..... Tel No: ..... Mobile No: .....	<b><i>Birth Certificate and Child Health Record/Red Book must be provided</i></b>  (2). Parent/Guardian Details: Name: ..... Address: .....  Relationship: ..... Tel No: ..... Mobile No: .....

**LIFESTYLE FACTORS – ALCOHOL (Must be completed by patient)**

How much alcohol, on average, do you drink in units each week? .....

What type of alcoholic drink do you prefer?    Beers/Spirits/Wine    Other .....

1 unit is typically:							
Half-pint of regular beer, lager or cider, 1 small glass of low ABV wine (9%), 1 single measure of spirits (25ml)							
The following drinks have more than 1 unit:	1.5 units Bottle of lager 	2 units Pint of lager 	3 units Pint of strong beer ale 	2 units 	4 units 'Super' lager 	2 units 175ml of 12% wine 	9 units Bottle of wine 

<b>How often do you have a drink containing alcohol?</b>	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week
<b>How many units of alcohol do you drink on a typical day you are drinking?</b>	1-2	3-4	5-6	7-9	10+
<b>How often have you had 6 or more units if male, on a single occasion in the last year?</b>	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
<b><i>For Surgery use only Score</i></b>					

### **CARERS**

Do you have a carer? (if yes please give details) .....

.....

**PERMISSION TO DISCUSS MEDICAL DETAILS WITH CARER**                      **Yes**      **No**

Are you a carer? (if yes please give details) .....

.....

### **SUMMARY CARE RECORDS**

This practice is Summary Care Record live, which means that your prescriptions, allergies and adverse reactions are saved on a central database for use by A & E and other care providers if you require treatment when the surgery is closed. If you wish to opt out of this scheme, or for more information, please ask at Reception.

### **TREATMENT**

Please detail treatment/medication currently being received or attach a medication list, including repeat prescriptions:

.....

.....

### **IMMUNISATIONS** *(Under 16 only)*

Please give details below:

.....

### **ETHNICITY**

*please tick box*

A	British/Mixed		D	W & B Caribbean		G	Other/Mixed		J	Bang/British Bang		M	African	
B	Irish		E	W & B African		H	Indian/British		K	Other Asian		N	Other Black	
C	Other White		F	White/Asian		I	Pakistani/British		L	Caribbean		O	Chinese	

First Language Spoken: .....

## **CURRENT AND PAST MEDICAL HISTORY**

Please give details of any illnesses, disabilities, allergies or operations with dates if possible:

.....

.....

Have you ever had any of the following? (*please indicate by circling the relevant illness*)

**High Blood Pressure**      **Angina**      **Heart Attack**      **Stroke**      **\*COPD**      **\*Diabetes**      **\*Asthma**      **Glaucoma**      **Cancer**      **Epilepsy**

***\*Please make an appointment with the Practice Nurse if you are due for your Chronic Disease Annual Review.***

## **FAMILY HISTORY**

Has any member of your family (Mother/Father/Brothers/Sisters) suffered from any of the following?  
Please indicate by ticking the relevant boxes and state which family member:

<b>Medical History</b>	<b>At what age?</b>	<b>Which Family Member?</b>
High Blood Pressure		
Angina		
Heart Attack		
Stroke		
Diabetes		
Asthma		
Heart Disease		
High Cholesterol		
Epilepsy		
Other		

## **ALLERGIES**

Are you allergic to any drugs? Please state which drugs:

.....

Any other allergies? Please give details:

.....

Our Practice offers a New Registration Health Check. If you would like to book an appointment for this please tick the box

☐

## **HIV TEST**

All adult patients in London are now being offered a free HIV test when they register with a new GP. The Department of Health recommends this as 100,000 people in the UK are now living with HIV, half of them live in London and 1 in 5 do not know they have it. If you would like to have a blood test done please ask your doctor or nurse at your next consultation or tick this box and we will contact you.

Do you know your HIV status? ☐ Yes please, I would like to arrange a free HIV blood test ☐

### **LIFESTYLE FACTORS – SMOKING**

Do you smoke? Yes / No If YES, how many cigarettes a day? .....

Did you ever smoke? Yes / No If YES, how many? .....

When did you stop? .....

**SMOKING DAMAGES YOUR HEALTH!  
WE ENCOURAGE YOU TO STOP AND WE WILL SUPPORT YOU**

**Please contact the following free helpline: 0300 123 1044  
Or you can visit the following website online at: [www.london.stopsmokingportal.com](http://www.london.stopsmokingportal.com)**

### **AGREED PRINCIPLES BETWEEN DOCTOR AND PATIENTS MEDICATION LIST**

Please read this carefully and sign the form showing us that you understand the details regarding the medical care we aim to provide our patients. Thank you.

- Appointments are made for one person at a time. Please do not bring anyone else unless they have their own arranged appointment.
- Patients arriving late for an appointment may be asked to rearrange it.
- Patients who frequently do not attend appointments with a doctor or nurse, without cancelling, maybe removed from the list.
- The Doctor will always try to see appropriate medical emergencies on the day.
- Please remember home visits are for those too ill to attend surgery.
- Please note that there is a 48 hour processing period for repeat prescription requests.

Patient's signature ..... Date .....

Clinician's signature ..... Date .....