Springfield medical centre
110 Union Road, London, SW8 2SH
Tel: 020 3049 4600 - Fax: 020 3049 4601

MALE PATIENTS

Main Language Spoken:	
Would you require an interpreter?	**Yes / No**
Your Email Address:	
Do you consent to be contacted via email? *Admin use: Yes -9Nds / No- 9Ndy*	**Yes / No**
Do you consent to be contacted by the surgery via text messages? *Admin use: Yes -9Ndp / No- 9NdQ*	**Yes / No**
We will contact you only to invite you for routine reviews, follow-up appointments (for example to discuss results) or regarding health campaigns (Flu jabs, NHS Health checks etc.). We will not enclose any results.	
Disclaimer - Any information sent via email is not secure. Please be aware that we cannot guarantee the security of any information sent via unencrypted email. If you are concerned about your personal details being visible to a third party, please do not use email.	

ETHNICITY – please tick by your ethnicity

WHITE		**Code**	**BLACK OR BLACK BRITISH**		**Code**
British		**A**	Caribbean		**L**
Irish		**B**	African		**M**
Any other White background		**C**	Any other black background		**N**
MIXED			**OTHER ETHNIC GROUPS**		
White and Black Caribbean		**D**	Chinese		**O**
White and Black African		**E**	Any other ethnic group		**P**
White and Asian		**F**	**NOT STATED**		
Any other mixed background		**G**	I do not wish to state my ethnicity		**Z**
ASIAN OR ASIAN BRITISH					
Indian		**H**			
Pakistani		**I**			
Bangladeshi		**J**			
Any other Asian background		**K**			

Religion _____ Marital Status _____

Allergies

Do you have any allergies to the following?

Penicillin ☐ Other Medication ☐ _____

Other Products

Nuts ☐ Milk ☐ Other ☐ _____

Illnesses	Yes	First diagnosed (month/year)	Medications (state if any and then give details in the table below)	Which hospital are you under?	Approximate date of last visit to hospital (month/year)	Is there any family history in the following
Asthma						
COPD						

Do you use Home Oxygen? Yes ☐ No ☐

Have you been hospitalised in an emergency for your breathing in the past 12 months? Yes ☐ No ☐

Diabetes						
Hypertension						
Heart disease						

Have you ever had a heart attack? Yes No When? (give date) _____

Have you had any heart operations? Yes No Which type? _____

Have you ever had a stroke? Yes No When? (give date) _____

CVA/Stroke						
Epilepsy						
Cancer						
Thyroid						
Depression						
Other?						

For patients aged 40 and over:

Last blood test for liver/cholesterol/kidneys? Month Year

if never or more than 5 years ago, please ask for this TODAY!

In the table below give details of any medications that you take

Medication

Are you on any medication? If so, please specify

Name	Strength	How many times/day

Operations

Have you had any major surgeries?

Name	Where/ Hospital	Date

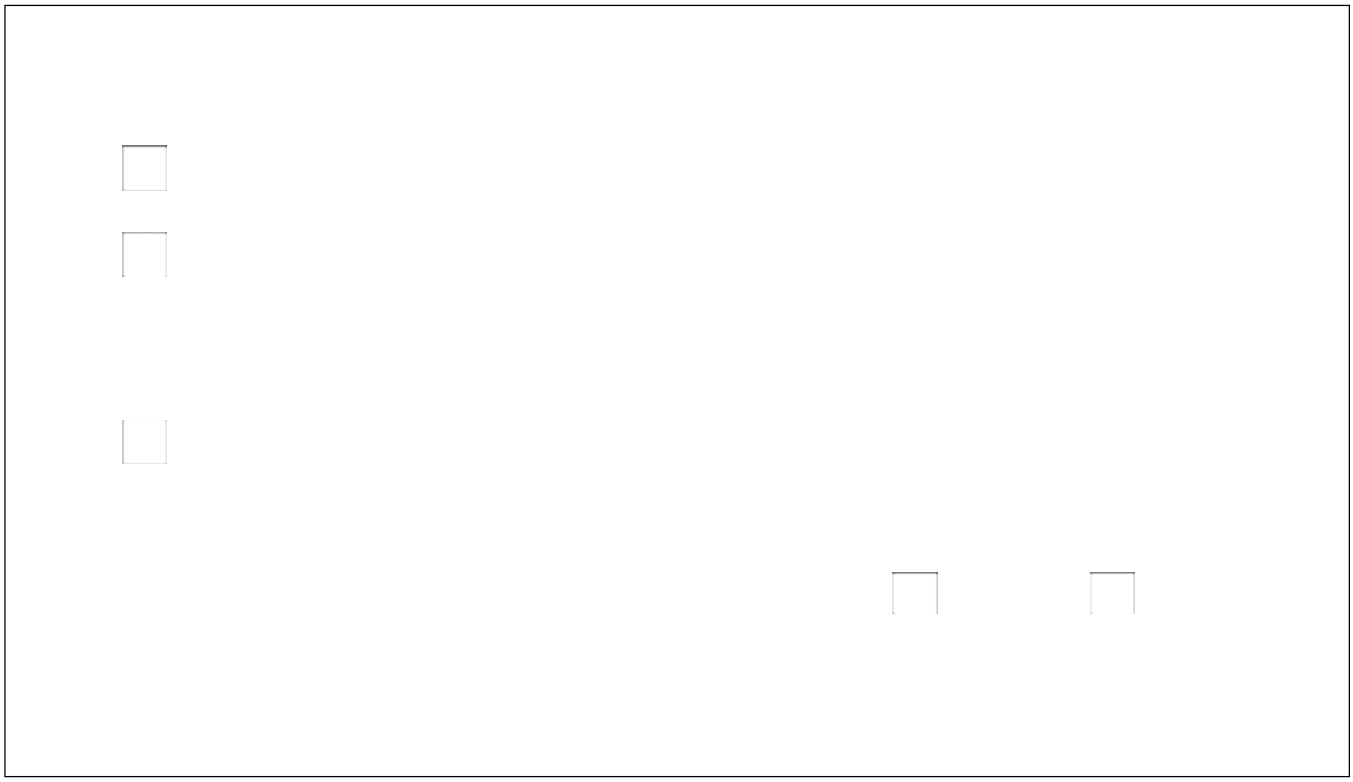
Carer Details

Are you a carer? Yes ☐ No ☐

Do you have a carer? Yes ☐ No ☐

Carer Name _____ Telephone _____

NEXT OF KIN ***Who to contact in case of emergency***	
Name:	
Surname:	
Contact Number:	
Email address:	
Relationship to patient:	



FAST

Questions	Scoring system					Your score
	0	1	2	3	4	
How often have you had 6 or more units of alcohol on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
If your score is 0, 1 or 2 on the first question then continue with the next three questions. If score is 3 or 4 on the first question – stop here. This indicates FAST positive.						
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
FAST SCORE						

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 – 4 times per month	2 – 3 times per week	4+ times a week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 8	10+	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Total (questions from this table)						
TOTAL AUDIT Score (all 10 questions)						

Nomination of Pharmacy for EPS	
Would you like to nominate a pharmacy for your electronic prescription services (EPS)?	Yes / No
Hiren – Next door pharmacy	Yes / No
Other Pharmacy? – Please Specify	
Name of pharmacy:	
Address of pharmacy:	