

**Hendon Way Surgery**

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| **New Patient Registration Questionnaire** |

Welcome to Hendon Way Surgery! Thank you for taking the time to complete this questionnaire in BLOCK CAPITALS

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| **PERSONAL DETAILS** | **Have you previously been registered at this practice before?** 🞎 Yes 🞎 No |
| Name: Mr/Mrs/Miss/Dr/Other:  |
| Address: | Date of Birth: / / |
| Postcode: | Occupation: |
| Home Tel: | Mobile: |
| Email: | NHS No (if known): |
| Main Language (if not English): | Do you need an interpreter? 🞎 Yes 🞎 No |
| Town of Birth: | Country of Birth: |

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| **ETHNIC ORIGIN** | Please tick one box only (recommended categories for National 2011 Census) |
| **White**🞎 British🞎 Irish🞎 Any other White background(Specify)…………………….. | **Mixed**🞎 White and Black Caribbean🞎 White and Black African🞎 White and Asian🞎 Any other Mixed background(Specify)………………… | **Asian or Asian British**🞎 Indian🞎 Pakistani🞎 Bangladeshi🞎 Any other Asian background(Specify)…………........ | **Black or Black British**🞎 African🞎 Caribbean🞎 Any other Black background(Specify)…………............ | **Other Ethnic Groups**🞎 Chinese🞎 Any other Ethnic group(Specify)………………….🞎 I DO NOT WISH TO STATE MY ETHNICITY |

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| **NEXT** **OF KIN** | Name: Address: Tel: Relationship to you: |

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| **CARERS** | Are you a carer for someone else? 🞎 Yes 🞎 No |
| Do you have a carer? 🞎 No 🞎 Yes – Carer’s Name and Contact Number:  |

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| **MEDICAL HISTORY** | Please tick if you have ever suffered or been treated for any of the following: |
| 🞎 Asthma 🞎 Epilepsy 🞎 Diabetes 🞎 High Cholesterol 🞎 Mental Illness 🞎 Cancer of:🞎 COPD 🞎 Stroke 🞎 High BP 🞎 Heart Disease 🞎 Thyroid Disorder 🞎 Other: |
| **If you have any chronic or significant medical conditions, please book a New Patient appointment to discuss it further.** |
| **MEDICATION** | Any allergies to any drugs/medicines? |
| Are you taking regular medication? 🞎 Yes 🞎 No Please state: ………………………………………………….If Yes, please book a New Patient Registration appointment. Please bring to this appointment all your medication (with packaging) and/or your repeat medication request slip from your previous GP (if applicable). |

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| **FAMILY HISTORY** | Please state if any family member has suffered from any of the conditions listed above: |
| **Illness / Condition** | 1. | 2. | 3. | 4. | 5. |
| **Family Member** |  |  |  |  |  |
| **Aged Diagnosed** |  |  |  |  |  |

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| **FEMALE PATIENTS ONLY** | Are you currently pregnant? 🞎 Yes 🞎 No If Yes, please book an appointment |
| If aged 25-64 years old, when did you last have a cervical smear test?Where was it done? What was the result?  |
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| **LIFESTYLE** | HEIGHT (approx.): cm | WEIGHT (approx.): kg |
| Do you smoke? Never smoked 🞎 Ex-smoker 🞎 Smoke Cigarette smoker/Roll on/Cigar/Pipe 🞎  How may cigarettes or grams per day? ............................................Please Tick if you would like to stop and ask Reception for details of Barnet Smoking Cessation Services 🞎 |
| Have you had a BLOOD PRESSURE check within the past year? Yes 🞎 No 🞎 If Yes, do you know the BP reading? \_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_mmHg |
| How many hours of exercise (which makes your heart race) do you take in an average week? \_\_\_\_\_\_Hours  |
| Do you have any special diet? No 🞎 Vegetarian 🞎 Vegan 🞎 Other 🞎 (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Contact authorisation**

If we need to communicate with you, how would you prefer to be contacted? *(Please select your preferred choice)*

Email: *(Please print current email address)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Text: Your mobile phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that my GP Practice will take all reasonable steps to keep my health information secure and private. I agree to allow the use of email or text messages for communication regarding health matters. I will inform the Practice if I change to a new GP Practice or change address or contact details including my email address and mobile phone number. Text messages are generated using a secure facility. I understand they are transmitted over a public network onto a personal telephone and as such may not be secure. However, the Practice will not transmit any information which would enable an individual patient to be identified. I acknowledge that appointment reminders by text are an additional service & that these may not take place on all occasions, and that the responsibility of attending appointments or cancelling them still rests with me.

Full Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **ALCOHOL** | Alcohol consumption is measured in units, which is explained in the diagram below: |
| **This is one unit of alcohol…****…and each of these is more than one unit**Please have a look at this diagram and then answer the questions on the next page |

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| **Questions** | **Scoring system** | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink containing alcohol? | Never | Monthlyor less | 2 - 4 times per month | 2 - 3 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 total score for the above 3 questions is 4 or less, then you do not need to complete the questions below** |
| **Questions** | **Scoring system** | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| 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 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 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 |  |
| 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 |  |
| 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 |  |
| Has a relative or 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 |  |
|  **Total AUDIT Score (Questions 1-10** |  |

**If you are concerned about your consumption of alcohol, please book an appointment with a Doctor or Nurse. Alternatively you can call: 0208 354 8962 or 0800 195 8100**

***Scoring:*** *0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence*

**NHS Summary Care Record:**

I consent / do not consent to allow a summary of my records to upload to the NHS Summary Care Record. If you do not consent then please complete the dissent form.(ask Reception)

The record will contain information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had to ensure those caring for you have enough information to treat you safely. Your Summary Care Record will be available to authorised healthcare staff.

**Record Sharing**

Do you consent to sharing your medical records with other NHS organisations caring for you, for the purposes of healthcare? This is known as sharing out.

 YES  NO 

 Do you consent to viewing the medical records shared by other NHS organisations caring for you, for the purposes of healthcare? This is known as sharing in.

YES  NO 

**Please book a New Patient appointment if you are on any regular medication or have any chronic or significant medical condition**

Please request a copy of the Practice Booklet if you have not already received it. Alternatively you can also find more information at www.hendonwaysurgery.nhs.uk.

I confirm that I have completed this form as accurately and honestly as possible and would like to apply to be registered as a patient at this practice

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: / /

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| **OFFICE USE ONLY** |  | **Staff Initials:** |
| Photo ID |  🞎 Passport |  🞎 Driving Licence  |  🞎 Identity Card |  🞎 Other  |
| Proof of Address |  🞎 Utility Bill |  🞎 Tenancy Agreement |  🞎 Bank Statement |  🞎 Other  |

Hendon Way Surgery

*Where care comes first*

 [www.hendonwaysurgery.nhs.uk](http://www.hendonwaysurgery.nhs.uk)

**Patient Registration**

**Previous GP Declaration**

Patient Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I ……………………………………………………………… hereby confirm that I never registered with a GP and/or Dentist nor have I ever been allocated an NHS number in England.

The above information is true and I agree that if the above information is found to be false then the local health authority has the right to take action accordingly.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_\_\_

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