hurley group

FAMILY DOCTOR REGISTRATION SERVICES

ADULT

For Official Use Only:

Form Accepted by:	
New patient health check appointment date	

Dear patient

By answering the question on this form you will be helping us to deliver better services to you as an individual. It is hoped that this will give us a better picture of the local population, which will help in planning new services and changing existing ones.

We encourage all patients to complete this form fully. The information you provide will be treated in the strictest confidence. Information you give will be treated in the same way as other information we hold within the health service and will not breech the Data Protection Act 2003. As has always been the case, no names or other identifying details are released from the practice when information is used for health service planning.

If you need any help to fill in this form, any **communication support** *needs (i.e. large print, easy read format, hearing aid, British Sign Language, language interpreter)* or have any queries regarding this form, please feel free to ask the reception team.

Thank you for your help.

Mr □ Mrs □ Miss □ Ms □ Other □ **Male □ Female □**

Surname _____ **DOB**_____/____/_____

First Name(s) _____

Previous Surname_____ **NHS Number** _____

Home Address

_____

_____

Town and Country of Birth _____

Telephone Number: 020 _____ **Mobile Number** _____

Work Telephone Number: _____

Marital Status: □ Married □ Single □ Other:

E-mail Address *(this will only be used for surgery correspondence)*_____

Are you housebound? Yes □ No □

Name of Next of Kin_____ **Contact Number**_____

Relationship to you _____

Please help us to trace your previous medical records by providing the following information;

Previous Address in the UK

_____

_____

Name and Address of your previous doctor

_____

_____

Are you from abroad? Yes □ No □

Your first UK address where registered with a GP

_____

Date you first came to live in UK _____

Employment Status
Please tick

Retired □ Student □ Unable to work □ Unemployed □ Employed as _____

If you have children of your own aged 16 years or under, please list their names and dates of birth below?

Names	Date of birth

NHS Organ Donor Registration

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.

□ Any of my organs and tissue or

□ Kidneys □ Heart □ Liver □ Corneas □ Lungs □ Pancreas □ Any part of my body

Signature confirming my agreement to organ/tissue donation:

_____ **Date:**_____

NHS Blood Donor Registration

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.

Tick here if you have given blood in the last 3 years □

Signature confirming consent to inclusion on the NHS Blood Donor Register my agreement to organ/tissue donation:

_____ **Date:**_____

Are you a carer?

i.e. Do you look after a friend or a relative who is sick, disabled, elderly has a mental heath problem or for any other reason?
Yes □ No □

Are you cared for?
i.e. Do you have a friend or relative who helps you live your day to day life?
Yes □ No □

If yes please give details of your carer's contact information:

Name _____

Contact Number: _____

Allerton Road Medical Centre is committed to ensuring that its services are accessible to everyone regardless of race, gender, ability, religion, sexual orientation or age. The information you give on this form will help us comply with our policy of ensuring equality in our services to you.

We recognise that some people may regard some of this information as personal and we have, therefore, included an option in most questions for 'prefer not to say'. You do not have to complete all of this form but it will help us improve our services if you can complete as much as possible and return the form.

All information collected around equality and diversity will be treated confidentially in accordance with the Data Protection Act. Access to this information will be restricted to staff involved in the processing and monitoring of this data. It will be used to provide statistical information only.

Ethnic Status, Nationality & Language

What is your country of birth?

What is your main spoken language?

What language do you prefer to read?

What do you consider to be your national identity?

Do you need an interpreter or translator?

Please tick the group that you feel most accurate described you:
This question is not about your nationality, place of birth or citizenship – it is about the group to which you as an individual perceive you belong. The descriptions are those used in government's 2001 Census.

White
White English □
White British □
White Irish □
White Scottish □
White Welsh □
White European □
White Non-European □
Other White background □

Asian
British Indian □
British Pakistani □
British Bangladeshi □
Indian □
Bangladeshi □
Indian □
Other Asian background □

Black
British Caribbean
British African □
Caribbean □
African □
Other Black background □

Chinese
British Chinese □
Chinese □

Mixed
White & Black African □
White & Black Caribbean □
White & Asian □
Other mixed background □

Jewish □

Other
Any other background please state _____

Religion/Beliefs:

Buddhism	□	Jewish	□
Judaism	□		
Christianity	□	Sikhism	□
Hinduism	□	No religion	□
Islam	□	Prefer not to say	□
Other (specify if you wish)	……		

Sexual Orientation

Bi-sexual	□	Lesbian	□
Heterosexual/straight	□	Other (specify if you wish)	……..
Gay	□		
Prefer not to say	□		

Disability

The Disability Discrimination Act 1995 (DDA) defines a person as disabled if they have a physical or mental impairment, which has a substantial and long term effect (i.e. has lasted or is expected to last at least 12 months) on the person's ability to carry out normal day to day activities.

Do you consider yourself to have a disability according to the terms in the DDA?
Yes□ No □ Prefer not to say □

Do you need extra support? Yes □ No □
If yes, please tick all that apply to you
□ Hearing impairment □ Communication needs □ Learning disability
□ Visual impairment □ Any mobility problems ; _____
□ Any other information that may help us look after you.
_____

Women's Health
(this next section is for women only)

Cervical Smears

Date Taken	At GP / Clinic	Results	Recall Date

Contraception
If you are using a form of contraception please list in the box below

Have you been screened for:

Chlamydia	Yes / No	If yes please tell us the date:
Breast Screening	Yes / No	If yes please tell us the date:

Personal Habits (all to complete)

Smoking, Alcohol & Exercise
Please tick which applies to you

Smoking

Never Smoked □ Non-Smoker □ Pipe □ Cigars □ Rolling Tobacco □
Current Smoker □ (if so how many per day) _____ Would you like us to help you stop yes/no
Ex-smoker □ (if so how many did you smoke per day) _____ and the date you stopped _____

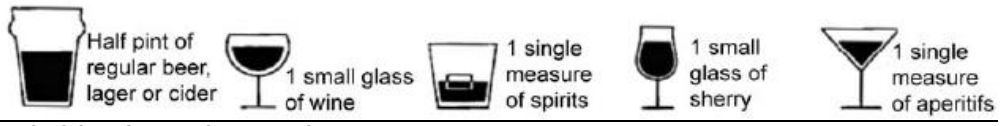
Alcohol Screening:

Do you drink Alcohol? ☐ Yes ☐ No ☐ Teetotal

If yes, _____ ***unit/week***

Please complete the Audit C below:

This is one unit of alcohol…



…and each of these is more than one unit

AUDIT – C

Questions	Scoring system 0	1	2	3	4	Your score
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 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	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

AUDIT – C

Based on 1 unit = ½ pint of beer or 1 glass of wine (125 ml) or 1 single spirits

Questions	Scoring System 0	1	2	3	4	Your Score
How often did you drink alcohol in past year	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only answer the following questions if your score is above 1.						
How many standard alcoholic drinks do you have on a typical day when drinking	1-2	3-4	5-6	7-8	10+	
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	
In the last year has a relative or friend, or doctor or other health worker been concerned about your drinking or suggested you cut down?	No		Yes, on one occasion		Yes, on more than one occasion	
Total Score	Add up your total score and enter it in the box on the right ⇒ If you score 3 or more, please complete the next questionnaire					

If you have scored more than 3, please complete part 2 on the next page. If you have scored less than 3 please skip the next page and continue onto the Exercise question.

Alcohol Screening Part 2 – only complete if your score was 3 or more in the questionnaire above.

Questions PART 2	**Scoring System** 0	1	2	3	4	**Your Score**
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 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 that you were not able to stop drinking once you had started?	**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?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**	
Has a relative/ friend/ doctor/ health worker been concerned about your drinking or advised you cut down?	**No**		**Yes, on one occasion**		**Yes, on more than one occasion**	
Total Score	**Add up your total score and enter it in the box on the right** ⇨ **Scoring 8-15 = hazardous drinking, 15-19 = harmful drinking, 20 or more = possible dependence**					

Exercise

Do you exercise regularly? Yes/No

If yes,

a) how often do you usually exercise?
less than once a week ☐ up to three times a week ☐ up to 5 times a week ☐ more than 5 times a week ☐

b) how long does your exercise usually last?
less than 10 minutes each time ☐ less than 30 minutes each time ☐ 30 minutes or more each time ☐

Do you suffer from any of these conditions?

	Approximately when diagnosed / Year
Diabetes	Yes / No
High Blood Pressure	Yes / No
Stroke	Yes / No
Osteoporosis	Yes / No
If Yes have you ever had a Dexa Scan?	Yes / No
Epilepsy	Yes / No
Asthma	Yes / No
Allergies or Hay fever	Yes / No
Eczema	Yes / No
Depression and/or Anxiety	Yes / No
Cancer	Yes / No

If yes, please state which type eg. Breast, colon, lung

Please detail any other conditions you suffer from that are not mentioned above:

Are you taking any medication? **If so, please tell us what you are taking**

Name of medication	**Dose of medication**

Have you had any operations in the past? If so, please give details in the space below.

Have you had any vaccines in the last 10 years? If so, please list, please include seasonal flu vaccine.

Do you have any allergies?

Medication	Food	Anything Else

Have you had an NHS Health Check in the past year **Yes / No**

Have you been screened for HIV **Yes / No**

Family History

Please let us know in this section of any illness that is in your family:

Disease	**Relative**
Heart Disease	
Stroke	
Hypertension	
Diabetes Type 1 or Type 2	
Asthma	
Cancer	
Any other	

Do you give your consent to have your medical records shared on the National Data Base? **Yes / No**

Would you like to have access to your medical records on-line? **Yes / No**

Would you like to be set-up to book appointments on-line? **Yes / No**

Would you like to be able to book your repeat prescriptions on-line? **Yes / No**

If you have answered yes to any of the above 3 questions, the surgery will contact you with your login details within 21 days.

Would you be interested in joining our Patient Participation Group **Yes/No**

This a group of patient representatives that meet at least 4 times a year to help make sure there is a good channel for getting patients views and input to the services offered by the practice. Please see our patient leaflet or ask reception for further details.

EPS (Electronic Prescription Service)

EPS makes it easy for your prescriptions to be sent electronically to the pharmacy or dispenser of your choice.

***** Nominated pharmacy :** _____

Thank you for taking time to complete this form.

Please ask at reception for a practice leaflet to explain the services we offer at our Practice

SIGNED: _____

DATE: _____

***** Please use BP machine, provided at the surgery *****

HEIGHT WEIGHT BMI

BP READING /

Dear patient, did you know you can consult our GPs online and you will get a response back from the GP by the end of the next working day. Visit www.allertonroadmedicalcentre.com to find out more.

Recording Consent of New Patients for Data Sharing Initiatives in Hackney

Summary Care Record National Initiative 	If you have a Summary Care Record your health care providers can view your • medication (last 12m) • bad reactions to medicines • allergies when you're admitted to hospital, when treating you in an emergency, or when your practice is closed.	I want to have a Summary Care Record. ☐ ***9Ndm*** I do **not** want to have a Summary Care Record. ☐ ***9Ndo***

Name: .....

Date of Birth: .....

Signature: ..... **Date:** .....

Please read the above text and make your selection by ticking the box or boxes next to the right statement. Then please fill out the required information below, sign and date the form and return it to reception.

Patient Online registration form
Access to GP online services

Surname			
First name			
Date of birth			
Address			
Postcode			
Email address			
Telephone number		Mobile number	

I wish to have access to the following online services (tick all that apply):

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐

If you have answered yes, you will need to provide a photo ID for the reception team to issue
you with a unique PIN number.

Signature		Date	