Perivale Medical Clinic

2 Conway Crescent, Perivale, London, UB6 8HX
Tel: 020 8997 2457 Fax: 020 8810 9489

New Patient Registration Questionnaire

Welcome to Perivale Medical Clinic! Thank you for taking the time to complete this questionnaire in BLOCK CAPITALS
Your name GP is Dr Narmen Koye

PERSONAL DETAILS	Have you previously been registered at this practice before? ☐ Yes ☐ No
Name: Mr/Mrs/Miss/Dr/Other	
Address: Postcode:	Date of Birth: / / 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:

ETHNIC ORIGIN	Please tick one box only (recommended categories for National 2011 Census)			
White	**Mixed/Multiple Ethnic**	**Asian / British Asian**	**Black/African/Caribbean/ Black British**	**Other Ethnic Group**
☐ English/Welsh/Scottish /Northern Irish/British ☐ Irish ☐ Gypsy or Irish Traveller ☐ Other White (Specify)……	☐ White and Black Caribbean ☐ White and Black African ☐ White and Asian ☐ Other Mixed (specify)……	☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese ☐ Other Asian (specify)……	☐ African ☐ Caribbean ☐ Other Black (specify)……	☐ Arab ☐ Other Ethnic (Specify)…… ☐ I do not wish to answer this question

NEXT OF KIN	Name: Tel: Relationship:

CARERS	Are you a carer for someone else? ☐ Yes ☐ No
Do you have a carer? ☐ No ☐ Yes – Carer's Name:	

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.

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					

MEDICATION	Any allergies to any drugs/medicines?
Are you taking regular medication? ☐ Yes ☐ No 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)	

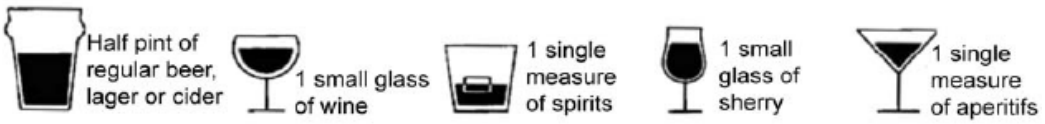
VACCINATIONS	Please provide the Personal Child Health Record ("Red Book") or Immunisation records. You can also record any immunisations in the space below		
Date	Immunisation	Date	Immunisation

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?	
If aged 16-25 years old and sexually active, please consider picking up a Chlamydia screening kit from Reception	

LIFESTYLE	Height (approx.)? cm	Weight (approx..)? kg
Do you smoke? ☐ Never smoked ☐ Ex-smoker ☐ Smoke …….. Cigarettes daily If you would like to stop, please ask Reception for details of Smoking Cessation Services at this Practice.		
Exercise: Mild/ Moderate/ Vigorous		

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

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 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

Please turn over the page

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

YOUR CONSENT MATTER TO US

PATIENT CARE TEXT MESSAGING, LETTER, EMAIL CONSENT

We may occasionally want to contact you to remind you of an appointment, sending you a letter for review, communicate via email.

DO YOU CONSENT TO US CONTACTING YOU BY SMS, LETTER AND/OR EMAIL?

☐ Yes SMS ☐ LETTER ☐ EMAIL ☐

☐ No

PLEASE ADVISE THE PRACTICE IF YOUR MOBILE NUMBER CHANGES OR IF THIS IMOBILE IS NO LONGER IN YOUR POSSESSION. THE SURGERY DOES NOT OFFER A REPLY TEXT MESSAGING SERVICE.

What is your preferred telephone number for us to contact you on or leave voicemail ?

OPT-OUT : YOU CAN CANCEL THE FACILITY AT ANY TIME, IF YOU WISH PLEASE CONTACT US IN WRITTING

REPEAT PRESCRIPTION

Please attached repeat prescription list from your old GP

Choose your nominated Pharmacy:

Name…….
Full Address:……
Tel: …….

YOUR CONSENT MATTER TO US

IF YOU REQUIRED ONE OR ALL OF THE FOLLOWING SERVICES, WE WOULD NEED TO OBTAIN YOUR CONSENT.

Your medication collection/requesting by third party. **Yes ☐**

Please tick who will be collecting or requesting.

Family member ☐ **Carer ☐** **Other ☐ Please specify**

Your letter collection/requesting by third party. **Yes ☐**

Please tick who will be collecting/requesting.

Family member ☐ **Carer ☐** **Other ☐ Please specify**

Your appointment made by third party. **Yes ☐**

Please tick who will be making.

Family member ☐ **Carer ☐** **Other ☐ Please specify**

OPT-OUT : YOU CAN CANCEL THE FACILITY AT ANY TIME, IF YOU WISH PLEASE CONTACT US IN WRITING

REPEAT PRESCRIPTION

Requesting : Names **Relationship to you**

1. …… **…….**

2. …… **…….**

Collecting : Names **Relationship to you**

1. …… **…….**

2. …… **…….**

OTHER PAPERWORK

Requesting : Names **Relationship to you**

1. …… **…….**

2. …… **…….**

Collecting : Names **Relationship to you**

1. …… **…….**

2. …… **…….**

BOOKING APPOINTMENTS

Names **Relationship to you**

1. …… **…….**

2. …… **…….**

NAME: **……** **DATE OF BIRTH:** **……**

SIGNATURE : _____

Privacy Protection

Our practice has a strict confidentiality policy. For more information please visit our website or ask a member of staff. This information is not shared with any third party organisations.

Summary Care Record – your emergency care summary

YES I would like a Summary Care Record containing details of my medications, allergies and any bad reactions to medications I have had	☐
YES I would like a Summary Care Record containing details of my medications, allergies and any bad reactions to medications I have had **AND** any other information that I have agreed with my GP Practice to have included in my Summary Care Records *Please indicate what information you would like adding if you know*	☐
NO I do not want a Summary Care Record	☐

Application Form for Online Access

1. Booking appointments	
2. Requesting repeat prescriptions	
3. Viewing Summary Information (Allergies, Adverse Reactions and Medications)	
4. Immunisations	
5. Test Results	

I wish to access my medical record online and understand and agree with each statement (tick)

1. I have read and understood the information provided by the practice	
2. I will be responsible for the security of the information that I see or download	
3. If I choose to share my information with anyone else, this is at my own risk	
4. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible	
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	
6. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible.	

I decline access to online services ☐

RECORD SHARING – As informed patient, in consultation with a Health Professional, can choose to permit or restrict access to the information entered on their record at each SystemOne organisation at which they receive care. We are one of the SystemOne organisation and therefore you need to make a choice.
The patients consent can be changed at any time.

PLEASE NOTE YOU WILL AUTOMATICALLY BE OPTED IN UNLESS YOU ADVISE OTHERWISE

SHARING OUT

Does the patient consent to the sharing of data recorded here with any organisation that may care for the patient?

☐ Yes – share data with other organisations

☐ No – do not share any data recorded here

SHARING IN

Does the patient consent to viewing of data by this organisation that is recorded at other care services that may care for the patient where the patient has agreed to make the data sharable?

☐ Consent Given

☐ Consent refused

Thank you for completing the questionnaire. New patients over the age of 5 should have a new patient health check with our nurse. Please arrange an appointment now at reception.

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

Signature: Date: / /

For practice use only

Identity verified and password created by Date:	Two types of ID checked Photo ID and proof of residence ☐ Please note the type of ID produced by the applicant here: Vouching:
Access Approved / Not approved	Date:
Level of record access enabled • Appointment Booking • Prescription ordering • View Summary Information • Immunisations • Test Results All ☐ Limited parts ☐	Notes / explanation

OFFICE USE ONLY	Need Appt? ☐ Yes ☐ No Need Etoh Advice? ☐ Yes ☐ No			**Staff Initials:**
Photo ID	☐ Passport	☐ Driving Licence	☐ Identity Card	☐ Other
Proof of Address	☐ Utility Bill	☐ Tenancy Agreement	☐ Bank Statement	☐ Other