CRANBROOK SURGERY

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NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE

To register with the Practice please complete this questionnaire as fully as possible. This information will help the doctor to make an initial assessment of your health which will assist in your future treatment.

PLEASE INFORM THE RECEPTIONIST IF YOU REQUIRE THIS FORM IN LARGE PRINT OR ANOTHER LANGUAGE

SURNAME:		FORENAME(S):			
DATE OF BIRTH:		TITLE:		GENDER:	
ADDRESS:					
HOME TEL:		MOBILE NUMBER:			
EMAIL ADDRESS:					
MARITAL STATUS:		OCCUPATION:			

Next of Kin: (Relative or friend in UK)		Contact number:	
Relationship to you			
Do you give permission for the practice to contact them?			

Ethnicity: Please Tick the appropriate Box

- ☐ (White) British
- ☐ (White) Irish
- ☐ (White) Other Background
- ☐ (Black or Black British) African
- ☐ (Black or Black British) Caribbean
- ☐ (Black or Black British) Other Background
- ☐ (Mixed) White & Black African
- ☐ (Mixed) White & Black Caribbean
- ☐ (Asian or Asian British) Bangladeshi
- ☐ (Asian or Asian British) Indian
- ☐ (Asian or Asian British) Pakistani
- ☐ (Asian or Asian British) Chinese
- ☐ (Asian or Asian British) Other Background
- ☐ (Mixed) White & Asian
- ☐ (Mixed) Other Background
- ☐ (Other) Any other

Nationality:		Religion:	
Country of Birth:		First Language:	

Do you require an interpreter present at your appointments? Yes / No (wherever possible please bring a person who can speak on your behalf. This will help the doctor to treat you more effectively)

If yes, please specify the language required: ________________________________

SMOKING

Do you smoke? Yes ☐ No ☐

If Yes, how many: Cigarettes per day: ☐ Cigars per day: ☐ Ounces tobacco per day: ☐

Other, please specify: ________________________________

How old were you when you started smoking? ______

EX-SMOKERS

How old were you when you stopped smoking? ______

How much did you smoke per day? ________

PASSIVE SMOKING

Are you exposed to smoke at work? Yes ____ No ____ At home? Yes ____ No ____

ALCOHOL

Do you drink alcohol? Yes ____ No ____

How many units of alcohol do you drink per week? _____

(1 unit = half pint of beer, 1 glass of wine, or a pub measure of spirits)

How often do you have a drink that contains alcohol? Circle as appropriate.

Never	Monthly or less	2-4 time per month	2-3 times per week	4+ times per week

How many alcoholic drinks do you have on a typical day when you are drinking? Circle as appropriate.

1-2	3-4	5-6	7-9	10+

How often do you have 6 or more standard alcoholic drinks on one occasion? Circle as appropriate.

Never	Less than monthly	Monthly	Weekly	Daily or almost daily

DIET

Do you add salt to your food after cooking?	**Yes**	☐	**No**	☐
Do you have a varied diet including milk, meat, vegetables and fruit?	**Yes**	☐	**No**	☐
Has your Cholesterol been checked in the last 2 years?	**Yes**	☐	**No**	☐

EXERCISE

Do you exercise regularly? Yes ☐ No ☐

If yes, what sort of exercise? ____

How many times per week? ____

PAST MEDICAL HISTORY

Please give details of any treatment for any chronic medical conditions:

Please give dates of any X-ray, MRI or CT scans, Mammogram, Ultrasound:

DIAGNOSIS AND MEDICATION

Please give details of any medication which you take (prescribed or otherwise):

Diagnosis:		**Name of drug:**		**Dosage:**	
Diagnosis:		**Name of drug:**		**Dosage:**	
Diagnosis:		**Name of drug:**		**Dosage:**	
Diagnosis:		**Name of drug:**		**Dosage:**	

PLEASE NOTE THAT A GP APPOINTMENT MUST BE MADE ON COMPLETION OF HEALTH CHECK. DOCTOR WILL REVIEW MEDICATION BEFORE ANY REPEAT MEDICATION CAN BE ISSUED.

Please allow 2 full working days when requesting a repeat prescription; repeat prescriptions will not be taken over the telephone (requests can be made by letter, email, via online request service, by visiting the practice and via the pharmacy).

ELECTRONIC PRESCRIPTION SERVICE (EPS) NOMINATED PHARMACY: _______________

FAMILY HISTORY

Did anyone in your family *(father, mother, brother, sister)* have any of the following before age of 65?						
Heart Disease (heart attacks, angina)	Yes		No		which family member?	
Stroke?	Yes		No		which family member?	
Cancer?	Yes		No		which family member?	

ALLERGIES:

Are you allergic to any substances or foods? Yes ☐ No ☐

If yes, please give details: ____

FEMALE PATIENTS:

Date of most recent cervical smear: ____

Result of most recent smear: __________(IF YOU HAVE, PLEASE SUBMIT COPY OF YOUR RESULT)

Please give details of any complications in pregnancy: _____________________________________

FAMILY CARERS:

Do you need / have anyone who looks after you or your daily needs as Carer?	Yes		No	
If "Yes", would you like them to deal with your health affairs here?	Yes		No	
Do you care for anyone else?	Yes		No	
If "Yes", ask the receptionist about Family Carers support	Yes		No	

Would you like to join our Patient Participation Group YES □ NO □

Would you like to book routine GP appointments online and order repeat prescriptions online? Y / N PLEASE ASK FOR A REGISTRATION FORM, (this can only be done once your registration has been accepted by the health authority)

SCR programme allows your medical record to be available to NHS staff to treat you in an emergency situation.
This information can only be access by authorised staff and will only be viewed in a serious emergency scenario.

By signing this form, you are confirming you have understood the statements below and understand the implications of opting in/out of the programme. Please ask for a leaflet for further details.

(Please tick one only)

- □ **I would like to opt in for my Medication, Allergies and Adverse reactions to be available to NHS staff in an emergency.**

- □ **I would like to opt in for my Medication, Allergies, and additional information to be available to NHS staff in an emergency.**

- □ **I would like to opt OUT of my Medication, Allergies and Adverse reactions to be available to NHS staff in an emergency.**

PATIENT CHARTER

Patients Rights & Responsibilities

Patients have the right to be given courtesy and respect at all times. Respect for religious and cultural beliefs will always be honoured. We ask that practice staff are also given this courtesy.
Patients have the right to be treated confidentially and to be given information regarding their own health.

Patients must inform the practice if they change any of their personal details. Patients must keep appointments made. They must inform us if they are not able to attend an appointment, giving us time to offer it to another patient.

Zero Tolerance Policy

A zero tolerance policy towards violent, threatening and abusive behaviour is in place throughout the NHS. At no time will any such behaviour be tolerated in this practice. If you do not respect the rights of our staff we may choose to inform the police and make arrangements for you to be removed from our practice list.

PATIENT CONFIDENTIALITY

While you remain a patient with this practice, we provide you with care and are required by law to maintain records about your health and any treatment or care you have received within the NHS. These records help to provide you with the best possible healthcare. We collect and hold data for the sole purpose of providing healthcare services to our patients.
Your data is collected for the purpose of providing direct patient care, however, we can disclose this information if: it is required by law; if you give us consent; or if it is justified in the public interest. We will always obtain consent from you before we share data for any other purpose. For further information, please ask a member of staff or visit: https://digital.nhs.uk/services/national-data-opt-out

Signed: ____ Date: ______________

PLEASE BE AWARE THAT REGISTRATION IS COMPLETED ONCE APPOINTMENT WITH NURSE FOR NEW PATIENT HEALTH CHECK HAS BEEN ATTENDED. This is your to ensure that we can document your personal medical history along with any significant family traits you may have.
YOU MAY NOT BOOK A GP APPOINTMENT UNTIL YOU HAVE ATTENDED THE CHECK UP.

OFFICE USE ONLY

Registration checklist: PLEASE REVIEW INFORMATION TAKEN, BOOK NPM APP

- **Completed registration questionnaire, PLEASE CHECK COMPLETED CORRECTLY AND SIGNED**
- **PLEASE CHECK: COUNTRY OF BIRTH, INTERPRETER, TB QUESTIONS, EPS, ONLINE REGISTRATION & SCR OPTIONS HAVE BEEN COMPLETED.**
- **Completed registration form – check previous address and date of entry have been completed OR ASK PT TO CONFIRM ON GMS1 IF FIRST ADDRESS AND/OR GP**
- **Previous GP name has been provided**
- **1 Proof ID: Copy of photo page of Passport and visa page/card MUST be taken**
- **1 Proof of address (i.e. Utility bill, Tenancy agreement or Bank statement) NOT MOBILE BILL**
- **Red Book (Children up to 5 years old) Copy of immunisation sheets must be taken or provided from country of origin**
- **Child over 5 years should have own NPM app with Nurse**

Checked by ………………….……. **Reviewed by S. Ahmad, November 2020 v2**