Surrey Docks Health Centre Male New Patient Registration

Sex	
Surname / Family name	
Previous Surname	
Forenames	
Calling name	
Date of Birth (day : month : year)	
Title	
Marital status	

Flat Number / House Name	
House Number and or Street Name	
Town	
Post code	

NHS Number	
Home Tel No	
Work Tel No	
Mobile Tel No	
Email address	

Carer's name	
Carer's address	
Carer's telephone contact	
Carer's relationship to patient	

Have you previously been registered with a GP in the UK?	
If you were not born here, when did you first enter the UK?	
Name of your previous GP in the UK (if you have had one)	
Your previous address in the UK (if applicable)	

Tracing past medical records:

Is this your first registration with a UK GP? Please circle>>

Yes	No

Name, address & phone of your previous UK GP (if you had one)

NHS Organ Donor Registration

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death.

Please circle as appropriate:

Kidney	Heart	Liver	Cornea	Lung	Pancreas	Any part of my body

Signature and date confirming consent to organ donation

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 give blood.

Tick here if you have given blood in the last three years:

Signature and date confirming consent to inclusion on the NHS blood donor register

Contacting you:

Is it ok for us to text you on your mobile with appointment reminders and health promotion service information? We will not pass your number on to anyone else. Please circle >>>>>>	Yes	No

Please give the name and phone number of the person you would want us to contact in an emergency, and their relationship to you. >>>>>>	

Country of Birth	

What is your first language?	

If English is not your first language, are you confident speaking it?	

If you are not confident speaking English, or have a sensory impairment, please let the receptionist know in advance of making an appointment.

Ethnic Origin:

Please tick one ethnic group which most closely applies to you.

☐ White British
☐ White Irish
☐ Other white ethnic group
☐ Black Caribbean and White
☐ Black African and White
☐ Other ethnic, Asian/White origin
☐ Other ethnic, mixed origin
☐ Indian
☐ Pakistani
☐ Bangladeshi
☐ Other Asian ethnic group
☐ Black Caribbean
☐ Black African
☐ Black, other, non-mixed origin
☐ Chinese
Other ethnic group, please specify >>>> ________

Your personal health information:

Please measure yourself using the height and weight apparatus provided, (if you are unable to do this yourself, please ask a receptionist for assistance).

Height in cm

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Weight in kg

Smoking information:

I have never smoked	
I am an ex smoker : Date when you quit:	
I currently smoke: please specify how much:	

Alcohol:

☐ I have never used alcohol

☐ I drink ……… units of alcohol per week.

Please answer these questions then add up your score at the end. Your answers can help us to advise you about your intake.

1 **- How often do you have six or more drinks on one occasion?**
Never ☐(0); Less Than Monthly☐(1); Monthly☐(2); Weekly☐(3); Daily/Almost Daily☐ (4)

2 **- How often during the last year have you been unable to remember what happened the night before because you had been drinking?**
Never ☐(0); Less Than Monthly☐(1); Monthly☐(2); Weekly☐(3); Daily/Almost Daily☐(4)

3 **- How often during the last year have you failed to do what was normally expected of you because of your drinking?**
Never ☐(0); Less Than Monthly ☐(1); Monthly ☐(2); Weekly ☐(3); Daily/Almost Daily ☐(4)

4 **- Has a relative or friend, a doctor or other health worker been concerned about your drinking or suggested you cut down?**
No ☐(0); Yes, but not in the last year ☐(2); Yes in the last year ☐(4)

TOTAL ……….

If you have scored 3 or more we would recommend seeing the practice nurse to discuss this further as your intake may cause a hazard to your health.

Family + Social History:

Do you know your family medical history? **YES** ☐ **NO** ☐

Now enter the age at which your relative developed any of these conditions. If you don't know the age, comments such as; 'Childhood' 'Teenage' 'Young Adult' '<60' or '>60' years will help.

	Father	Mother	Brother	Sister	Mother's mother	Mother's father	Father's mother	Father's father	Other Rels.
Heart Disease									
Stroke									
Diabetes									
High Blood Pressure									
Transient Ischemic Attack									
Other (please specify)									

Please add any other specific information about your family or a partner if you think it is important for us to know

Current Medical Problems:

	Describe	When Diagnosed
Medical Problems		
Mental Health Problems		

Allergies:

Please include any reactions to medicines you have taken as well as any non medicine allergies e.g. bee stings, or foods.

Past Medical Problems:

	Describe	When Diagnosed
Operations		
Mental Health Problems		
Medical Problems		

Current Medication:

If possible please attach a copy of your previous GP's repeat prescription request form if you have one.

Medication on prescription

Name of Drug	Dose	How Often

Medication you buy over the counter

Name of Drug	Dose	How Often

NEW PATIENT HEALTH DETAILS QUESTIONNAIRE DECLARATION

We will use the information given by you today to update your electronic patient record. It is important for us to know whether this health summary is complete. Please either sign and date the form below or make an appointment.

The information recorded in this questionnaire is, to the best of my knowledge, a full account of my past and current medical history.

Signed:………………………... Print Name:……………............... Date: DD/MM/YYYY

If you are unable to sign above, you must now make an appointment for a new patient medical. We will be unable to register you properly if you do not do this.

Important Information about your health records

We would like to inform you about the introduction of the **NHS Summary Care Record** and your choices**.** The NHS Summary Care Record will affect the way in which your health records are managed at this surgery.

The NHS Summary Care Record is being introduced to help deliver better, safer care. Your NHS Summary Care Record is an electronic record of important information about your health. It will be available to healthcare staff providing your NHS care, which means if you have an accident or become ill, the clinicians treating you in accident and emergency, walk-in centres or GP out of hours services will have immediate access to important information about you (once fully rolled out at a later date).

In the first instance, your NHS Summary Care Record will contain any allergy details you may have, current medication and bad reactions to medicines. It will also contain details about your end of life care if this applies to you. At a later date, we plan to add other important medical information such as serious illnesses and test results. The NHS Summary Care Record will be in addition to your existing health records which will continue to be used as they are now.

Your choices

You do not need to do anything if you are happy to have a NHS Summary Care Record as it will be created for you automatically. This is planned to happen over the next 12 to 18 months.

Children under 16 years old on 28th April 2010 will have a NHS Summary Care Record created automatically. If, for any reason, you do not wish for a record to be created for any child under your care please let us know

If you do not wish to have a summary care record created for you, we recommend that you read the information on the website below before making a final decision.

Please indicate your preference to us on the page overleaf

More information

- The NHS Care Records Service Information Line on 0845 603 8510 (seven days a week; 7am–10pm) — calls from BT land lines will be charged at local rates.
- Website information: www.nhscarerecords.nhs.uk or
- http://www.southwarkpct.nhs.uk/patient_information/summary_care_record/ www.southwarkpct.nhs.uk/patient_information

Please Tick ONE of the boxes below and sign

I am happy for a Summary Care Record to be created for me ☐

I have read the information and I do not want to have a Summary Care Record created for me ☐

Name: ________________________

Signed: ________________________

Date: _________________________