PRIORY AVENUE SURGERY

ADULT - NEW PATIENT REGISTRATION FORM – CONFIDENTIAL

Please complete the **all sections** following form using **BLOCK CAPITALS** and return it to the surgery so that we can proceed with your registration. The information provided will be entered into your computer record, and will help us to give you the best possible care, especially if you also respond to the invitation for a health check with the Practice Nurse.

Title: Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other (please specify)……..

First Name and Surname/s: ……..……**Previous Surname**……

Date of Birth (dd/mm/yyyy): ……..…… **Sex:** Male ☐ Female ☐

Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Cohabiting ☐

Address including Postcode: (Please print)

Tel. No.: Home……..…….. **Mobile** ……..…… **Work** ……..……

Email address: ……

Do you have any information or communication support needs relating to a disability, impairment or sensory loss?

Please specify (e.g. Large Print) ……

Ethnic Origin (please tick): *Please note this information is used to establish disease trends*

White British	☐	Indian	☐	Mixed white/black Caribbean	☐
White Irish	☐	Pakistani	☐	Mixed white black African	☐
Other white	☐	Bangladeshi	☐	Mixed white/Asian	☐
Black Caribbean	☐	Chinese	☐	Other mixed	☐
Black African	☐	Other Asian	☐	Other ethnic group (Please specify)	☐
Other black	☐			Prefer not to answer	☐

Religion: …… **First spoken Language:**……

Next of Kin name: ……

(A person's next of kin is that person's closest living blood relative or somebody that you would want to contact in the case of an emergency)

Relationship to yourself: ……

Address: ……

Tel. No.: ……

Are you a carer for anyone? Yes ☐ No ☐

(A carer is anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support)

If yes, whom for? ……

Do you have a carer? Yes ☐ No ☐ **If yes, please provide their name and address:**

Do you currently smoke? Yes ☐ No ☐ **If yes, how many a day?** ……..

Have you ever smoked? Yes ☐ No ☐ **If you have stopped smoking, how long ago?**……

We would advise all our patients to stop smoking. If you would like help & support in stopping smoking please contact the NHS Stop Smoking Service on 0800 622 6360 or visit their website **www.smokefree.nhs.uk**. This is a FREE service.

Height: ……..……**Weight:** ……..……**When was your last tetanus vaccination?** ……..…

Blood Pressure Reading:……../……mmHg ……..beats/min
(There is a machine available to use in the waiting room)

Please give details of any regular exercise you undertake:

Please list below any regular medication that you take, whether you get it from your doctor or buy it over the counter?

Would you like to nominate a pharmacy where your prescriptions can be sent electronically? Yes/ No

Please give name & address of nominated Pharmacy

Do you have any known allergies? Yes ☐ No ☐ **If yes, then please list below:**

……

Do you have any current medical problems? Yes ☐ No ☐ **If yes, then please provide detail below:**

Have your parents, brothers, sisters or children ever suffered from the following? (please tick)

Heart disease ☐ **Diabetes** ☐ **Stroke** ☐ **Cancer** ☐ **Asthma** ☐ **High blood pressure** ☐

Glaucoma ☐ **Other (Please detail)**

If yes, then please give further details below, including family member affected:

Is there anything else you wish to tell us about?

Ladies

When was your last cervical smear? ……**Was it normal** ☐ **abnormal** ☐

Was the smear carried out under the NHS? Yes ☐ No ☐ **If no, where?**……..……

If you have had a normal smear within the last 3 years outside of the NHS, and do not wish to be offered another smear until the next smear is due, the receptionist will give you a form to sign that gives us permission not to invite you. Otherwise, we are obliged to send you an invitation on a regular basis, until you have a smear.

Are you currently pregnant? Yes ☐ No ☐ If yes, when is your baby due ……..

New Patient Check - All new patients are eligible for a new patient check with our Health Care Assistant. Would you like an appointment for a new patient check? Yes ☐ No ☐

Your information will be uploaded to the National NHS Spine unless advised to the contrary.

PLEASE CONFIRM YOUR AGREEMENT TO THE ABOVE Yes ☐ No ☐

You confirm that the practice may contact you by telephone (land line or mobile) and that if required, messages may be left on a named answer phone. You also agree that we can provide general practice information via email and SMS text messages.

Thank you for your time.

Please sign and date below

Signed …… **Date** ……

Priory Avenue Alcohol Questionnaire

What is your Alcohol intake per week? :

Please also complete alcohol questionnaire attached.

A Guide to a unit of alcohol:

Large (250ml) glass of wine - 3 units
Standard (175ml) glass of wine - 2 units
Pint of standard lager - 2.3 units
Single measure of spirits – 1 unit
Pint of premium lager - 2.8 units
Pint of strong cider - 4.7 units

So that we can advise you appropriately, please answer the following:

Questions	Score 0	Score 1	Score 2	Score 3	Score 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 standard alcoholic drinks do you have on a day when you are drinking?	1 or 2	3 or 4	5 or 6	7 or 8	10 or more
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

Total score from the above 3 questions……

If you score 5 or more please can you answer the following:

Questions	Score 0	Score 1	Score 2	Score 3	Score 4
How often in the last year have you found 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?	No		Yes but not in the last year		Yes during the last year
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year

Scoring:
0-7 = sensible drinking, 8-15 = hazardous drinking, 16-19 = harmful drinking and 20+ = possible dependence

The doctor will contact you if your responses cause any concern. If you feel that the amount of alcohol that you drink is a problem and you would like to talk to a doctor please make an appointment.

Information required as part of government statistics.

NHS England's Care Data – Registering an objection

NHS England's care.data system aims to provide timely, accurate information to citizens, clinicians and commissioners about the treatments and care provided by the NHS.

Please refer to the NHS England's care.data patient information leaflet before completing this form.

The NHS England's care.data patient information leaflet can be found in our surgery waiting room; on our website (www.prioryavesurgery.co.uk) (www.england.nhs.uk/ourwork/tsd/care-data/).

If you do not want information that identifies you to be shared outside your GP practice, you can ask your practice to make a note of this in your medical record. This is called an objection. An objection will prevent your confidential information being used other than where there are exceptional circumstances or where the law allows your information to be shared.

OBJECTION FORM – Confidential

A. Please **tick this box** if you **do not** want any information containing data that identifies you from leaving your GP practice. This type of objection will prevent the identifiable information held in your GP record from being sent to the HSCIC secure environment. It will also prevent those who have gained special legal approval from using your health information for research. The surgery will block the uploading of your identifiable and personal information to the HSCIC. ☐

B. Please **tick this box** if you **do not** want information containing data that identifies you from leaving the HSCIC secure environment. This includes information from all places you receive NHS care, such as hospitals. If you object, confidential information will not leave the HSCIC and be used in this way, except in very rare circumstances for example in the event of a civil emergency. The surgery will code your record which will alert the HSCIC not to use your information in this way. ☐

If you wish to cancel this at any time in the future please let reception know.

C. Please complete in BLOCK CAPITALS

Title: _____ Surname / Family Name: _____

Forename: _____ Date of Birth: _____ _____

Address: _____

Postcode: _____ Phone No.: _____ _____

Signature: _____ Date: _____ _____

D. If you are filling out this form on behalf of another person or a child, please ensure that you fill out their details in section C and your details in section D.

Your Name: _____

Your Signature: _____

Relationship to Patient: _____ Date: _____

Please return this form to reception and your records will be coded accordingly.