**FOR COMPLETION BY STAFF ONLY**

**New Patient appt booked for** ………………………………………..

.

**1**

**DRS PARRISH AND PAREKH**

**212 Richmond Road, Kingston upon Thames, Surrey KT2 5HF**

**020 8546 3136 (Appointments and Results)**

**NEW PATIENT QUESTIONNAIRE*Welcome to our practice. Please complete as many of the questions as you can – the information will be of importance in our effort to provide you with good medical care. Please PRINT and after completion return the form to the Receptionist.***

NAME: ………………………………………….. Date of birth: ………………….

ADDRESS: ………………………………………………………………………….

………………………………………………………POST CODE: ……..………..

HOME TELEPHONE NO: ……………………………………….. Sex: Male/Female

MOBILE:…………………………………………….EMAIL…………………………….

Place of birth: ………………………………

Have you ever lived abroad: Yes/No. If “YES” where and when? …………………………………………………………………………………………

Occupation: ………………………………………………………………………….

Height……………………………..Weight…………………………

**--------------------------------------------------------------------------------------------------------------------------------**

**CARER:**

Do you care for anyone else (Not being paid, agency or voluntary carer)? Yes/No

(If Yes, Practice offers a Carers Support Form, needs coding -“is a carer”)

**NEXT OF KIN: Name:……………………………………………Tel Number:………………………**

**Relationship to patient:…………………………………………………………………………..**

**-----------------------------------------------------------------------------------------------------------------------------**

 **We’re improving the way we communicate with our patients. If you need information in a different format or communication support, please specify below:**

**WOULD YOU LIKE TO JOIN OUR PATIENT PARTICIPATION GROUP?**

We welcome new members so if you would like to join St Albans Surgery Patient Participation Group (which could be either meetings or virtual) and are happy for us to contact you by email then please tick here**: □** where possible

**2**

|  |  |
| --- | --- |
| **HEALTH HISTORY****Date (if known)** | **Please list any serious illnesses, accidents, operations or disabilities** |
|  |  |
|  |  |
|  |  |

**ALLERGIES:**

Are you allergic to any medicines, food or other substances. Yes/No

Please give the details:

**EXERCISE:**

Do you take regular exercise? Yes/No

If “Yes”, what sort of exercise? …………………………………………………………………………………………….…

How many times a week? …………………………………………………………………………………………………….

**ALCOHOL:**

Do you drink alcohol? Yes/No

If “Yes” how many glasses of wine per week? ………………………………………………………………………………

How many measures of spirit per week? …………. How many pints of lager/beer per week? ……………………

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

**FEMALE PATIENTS ONLY:**

Are you over age of 50 and have not had a breast screening in the last 3 years?.............................................

When was the last time you had cervical screening? (females 25 – 64)………………………………………………...

 Please give the result if known ………………….....……………………………………………………………...............

What form of contraception used ……………………………………………………………………………………..…..

Please give details of any complications in pregnancy …………………………………………………………………....

**MALE AND FEMALE:**

Are you over age of 60 and have not had a bowel screening in the last 2 years?.....................................

**IMMUNISATIONS:** (CHILDREN UNDER FIVE YEARS OF AGE)

|  |  |
| --- | --- |
| VACCINE GIVEN | DATE |
| 1st Triple (DTP & Polio) HIB & Men-C |  |
| 2nd Triple “ “ “ |  |
| 3rd Triple “ “ “ |  |
| Pneumococcal 1 [ ], 2 [ ], 3 [ ]  |  |
| MMR1 Mumps, Measles & RubellaMMR 2 (German Measles) |  |
| Pre-school booster |  |
| Others (inc. BCG, Measles) |  |
| School Leavers Booster D/T and Polio |  |

**3**

**Collection of Smoking and Ethnicity Data**

As part of your health care, it is important that your doctor has your current smoking status recorded on your files. The Department of Health has requested that we collect ethnicity data to ensure that everyone has equal access to health care.

**Simply tick the appropriate boxes and hand back in to reception.**

|  |  |  |
| --- | --- | --- |
| **First Name:** | **Surname:** | **Date of birth:** |
| **Smoking Status** |  | **Please tick** | **For Office Use Only** |
| Never smoked |  |  | **1371** |
| Current smoker | 0 – 9 cigarettes a day |  | **1373** |
|  | 10 – 19 cigarettes a day |  | **1374** |
|  | 20 – 39 cigarettes a day |  | **1375** |
|  | 40 + cigarettes a day |  | **1376** |
| Currrent Smoker | Pipe/Cigars |  | **1375H** |
| Current Smoker | Cigar Smoker |  | **137J** |
| Ex-smoker | Age when stopped |  | **137S** |

**PASSIVE SMOKING**

Are you exposed to smoke at work? (Yes/No) At Home? (Yes/No)

**If you are a smoker and would like advice to help you stop smoking, then please speak to a member of our reception staff about our smoking cessation clinics. For more information on smoking please use this link** [**https://www.nhs.uk/oneyou/smoking**](https://www.nhs.uk/oneyou/smoking) **(Emis code 8CAL)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Ethnic Category** |  | **Please tick** | **For office use only** |
| White | British |  | **9S10** |
|  | Irish |  | **9S11** |
|  | Other White |  | **9S12** |
| Mixed | White & Black Caribbean |  | **9SB5** |
|  | White & Black Asian |  | **9SB6** |
|  | White & Asian |  | **9SB2** |
|  | Other Mixed |  | **9SB4** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Ethnic Category** |  | **Please tick** | **For Office Use Only** |
| Asian/Asian British | Indian |  | **9S6** |
|  | Pakistani |  | **9S7** |
|  | Bangladeshi |  | **9S8** |
|  | Other Asian |  | **9SH** |
|  | Sri Lankan |  | **13ef** |
|  | Korean |  | **13ee** |
| Black/Black British | Black Caribbean |  | **9S2** |
|  | Black African |  | **9S3** |
|  | Other Black |  | **9SG** |
| Other Ethnic | Chinese |  | **9S9** |
|  | Other Ethnic Category |  | **9SJ** |
| Not Stated |  |  | **9SE** |

**Thank you for completing this questionnaire.**

**4**

**FAMILY HISTORY:**

State present health and any serious illnesses suffered by:

Father…………………………………………………………………………AGE:…………………………………………..

If deceased state cause: ………………………………………………………………………….………………..………

Mother ……………………………………………………………… AGE:.……………………………………..…………

If deceased state cause: ……………………………………………………………………………………………………

Have you any siblings (brother or sister) with any significant medical problems.

If “Yes” please give details………………………………………………………………………………………………….

Is there a history of heart disease (heart attacks, angina) in your family? ……………………………………..……..

If “Yes”, please give details …………………………………………………………………………………………………

Are you single/married/separated/divorced or widow/er (please circle)

Name of partner (if applicable)……………………………………………………………

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DRUGS AND MEDICINE**

Are you taking any medicine or treatment:

If “Yes” you will need to make an appointment with the doctor before we can issue you with your first prescription.

If you are 40-74 years of age and not on a chronic disease register then you can ask for a free NHS Health Screening.

If you don’t qualify for a free NHS health check you can still make an appointment with our HCA for a New Patient Screening that will include blood pressure, height, weight, alcohol consumption and smoking.

**NHS ORGAN DONOR REGISTRATION:** The law has changed so that you now need to opt out if you do not want to become a Donor. It is important that you talk to your family about your organ donation decision as they will be asked to support your decision. If you are undecided or do not want to become an organ donor please contact the NHS Organ Donation website at [www.organdonation.nhs.uk](http://www.organdonation.nhs.uk) or 0300 123 23 23.

**5**

|  |
| --- |
| **CHLAMYDIA TEST**St Albans Medical Centre are now offering all their newly registered patients aged 15 and over a chlamydia test. This involves a urine sample.If you would like this please tick this box  |

|  |
| --- |
| **HIV TEST**St Albans Medical Centre are now offering all their newly registered patients aged 16 and HIV test. This involves having a routine, non-fasting blood test and the results are normally available in a week. If you would like this test please tick this box  |

**Full Name (printed)……………………………………………..**

**Signature ……………………………………………………Date of Birth………………………………..**

**Date of completion of this form …………………………..**

**Telephone / Mobile Number………………………………..**

**6**

**This is one unit of alcohol…**

****

**…and each of these is more than one unit**

****

**AUDIT – C**

|  |  |  |
| --- | --- | --- |
| **Questions** | **Scoring system** | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink containing alcohol? | Never | Monthlyor 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.

**SCORE**

**A SCORE OF 5 OR MORE – PLEASE**

**COMPLETE PART 2**

**7**

**Score from AUDIT- C (PART 2)**

**SCORE**

**Remaining AUDIT questions**

|  |  |  |
| --- | --- | --- |
| **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 |  |

**Scoring:** 0 – 7 Lower risk, 8 – 15 Increasing risk,

 16 – 19 Higher risk, 20+ Possible dependence

**TOTAL = =**

TOTAL Score equals

AUDIT C Score (above) +

Score of remaining questions

|  |
| --- |
| **Patient’s NHS Data Sharing** **Information and Preferences - Kingston** |
| **Kingston GP Chambers & other****Local** Initiatives | Local Data Sharing with Kingston GP Chambers enables your local NHS Kingston care providers, to view the relevant clinical information about you, when they are treating you in a consultation, and so give you the best possible care. These include Evening, Weekend and Bank Holiday GP services when your surgeries are closed. Its also in the local Specialist Clinics you may be referred to. This data sharing also enables immediate access for your own GP, on treatment and advice you have received elsewhere. | I am happy with and agree tolocal data sharing *(No action needed)*Or I want to: Opt out of local services sharing *(EMIS sharing consent)* |
| **Connecting Your Care****South West London** (Soon to expand to include other London hospitals). | Connecting Your Care is a recently completed Interoperability Project which created a portal to link up all your medical records that are held with Hospitals, Community Care and your GP Practice. This data sharing is only available to the organisations that you are treated by. It is invaluable to clinicians to have access to your full history in one place when they need it. For more information go to:<https://www.swlondon.nhs.uk/ourwork/connectingyourcare/>If for any reason you would like to find out more or to opt out of the data sharing you should contact the Connecting Your Care Team:Email: connectingyourcare@swlondon.nhs.uk Phone:  0203 668 3100Post: Freepost – SWL CONNECTING YOUR CARE |
| **Summary Care Record***also known as****SCR***summary care records**National** Initiative | Having a **basic** **Summary Care Record - SCR**, enables health care providers, to view your * medication (last 12m)
* bad reactions to medicines
* allergies

when you’re admitted to hospital, or when treating you in an emergency, around the country. **Additional Information SCR**Having this allows for more details of your significant medical history and specialist needs, to be included in your SCR. This is particularly important, if you have long term conditions, or have specialist needs or instructions for your care. It can also include next of kin details. The SCR is used by hospitals and ambulance services around the country.<https://digital.nhs.uk/services/summary-care-records-scr/summary-care-records-scr-information-for-patients> | I want to have a Summary Care Record. *(No action needed unless opted out before)*I want a Summary Care Record with medication, allergies**, and**  **Additional Information** *(Emis sharing SCR)*I do **not** want to have a Summary Care Record.  *(Emis sharing SCR)*  |
| **National** Initiative**National NHS Data** *Data required for general medical research and NHS management, but not related to providing you with direct care.* | **Research and planning**Confidential patient information might also be used to plan and improve health and care services, research and develop cures for serious illnesses**Your choice**You can stop your confidential patient information being used for research and planning. If you’re happy with your confidential patient information being used for research and planning, you do not need to do anything. Any choice you make will not impact your individual care. See nhs website for more information:<https://www.nhs.uk/your-nhs-data-matters/manage-your-choice/>*(This replaced the care data opt out code 9Nu0, in March 2018. (SNOMED - Dissent from secondary use of GP patient identifiable data) The current opt outs will be respected until 2020 by which time they should be replaced by the new ‘online’ or ‘phone in’ version for you the patient to update Tel: 0300 303 5678 or visit the website above)* |

|  |  |  |
| --- | --- | --- |
| **Name:** |  | **Date of Birth:** |
| **Signature:** |  | **Date:** |

# Application for online access to my medical record 9

This only applies to patients 16 years and over

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

**Would you like to start receiving communications, such as appointment reminders, from our practice via:**

**SMS text messaging: YES** 9Ndp **NO** 9Ndq

**\*Email: YES** 9Nds **NO** 9Ndy \*(currently **NOT** in operation)

**We are now giving access to PROXY users for patients aged 0 – 11. This is for appointments and prescriptions ONLY.**

|  |
| --- |
| **Name of proxy user:** |
| **Relation to patient:** |
| **Email address:** |
| **Signature:** |

NOTE: When the patient reaches the age of 11 the proxy user will receive an email notifying them that access will cease. The patient will be able to regain the access themselves when they reach the age of 16.

**Proxy access can also be given to Carers but for this we will need patient written consent.**

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

|  |  |
| --- | --- |
| 1. Booking appointments
 | 🞏 |
| 1. Requesting repeat prescriptions
 | 🞏 |
| 1. Accessing my medical record
 | 🞏 |

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

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the practice. Also on our website under Registration section – “Online Services Records Access Leaflet”.
 | 🞏 |
| 1. I will be responsible for the security of the information that I see or download
 | 🞏 |
| 1. If I choose to share my information with anyone else, this is at my own risk
 | 🞏 |
| 1. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement
 | 🞏 |
| 1. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible
 | 🞏 |

**You will need a password from the Practice to register. Would you like us to send it to you by email 🞏 or other method 🞏 (please specify). Please read carefully the leaflet attached about being responsible for keeping your login details safe.**

|  |  |
| --- | --- |
| Signature | Date |

### 10

### For practice use only

|  |  |  |
| --- | --- | --- |
| Identity verified by(initials) | Date | MethodVouching 🞏Vouching with information in record 🞏 Photo ID and proof of residence 🞏 |
| Authorised by  | Date |

**THERE IS SO MUCH MORE TO OFFER DIGITALLY**

COVID times: You may now register for online services via NHS App without coming to the surgery with your ID.

For Text messaging and for online services, as above, if you prefer not to use the NHS App, we will still need this completed form verified with your ID (visit the surgery with your ID which we can check from a distance).