THE AVENUE SURGERY

NEW PATIENT REGISTRATION QUESTIONNAIRE

To register with the Practice you need to complete this questionnaire as fully as possible

Do you have any special communication needs? Please tick

Yes ☐ No ☐

If yes we will ask you to complete a more detailed form to clearly understand any communication support you may need as a result of disability, impairment or sensory loss.

Surname: …… Maiden Name: ……

Forenames: ……Title: Mr/Mrs/Miss/Ms Other…….

Date of Birth: …….. Marital Status: ……

Address: ……

……..Post Code..……

Home Tel: …… Mobile ……..

NHS Number (if known) ……..

SUMMARY CARE RECORD (SCR)

If you are registered with a GP practice in England you will have a Summary Care Record (SCR) unless you have chosen not to have one. Your SCR contains important information about any medicines you are taking, any allergies you suffer from and any bad reactions to medicines that you have previously experienced.

It is not compulsory to have a Summary Care Record but if you choose to opt out of the scheme you must complete an opt out form which you can obtain from Reception at The Avenue Surgery.
It would be helpful, if decide you want to have a Summary Care Record if you could give us your explicit consent.

I have read the information given, and consent to my practice uploading to the National Electronic Database a Core Summary Care Record for me.

Yes ☐ **No** ☐

SMS Messaging: Would you like to receive text message reminders and other notices from The Avenue Surgery via text in the future when this service becomes available? Yes / No

Email Address: ……

Email Messaging: Would you like to receive email message reminders and other notices from The Avenue Surgery in the future when this email service becomes available? Yes / No

I consent to receiving appointment confirmations, reminders and other notices via text message and/or email when this service becomes available and will update the Surgery of any changes to my mobile number/email address. I have read the terms and conditions at the end of this form.

Occupation: ……..

Full-time Student Yes/No

Weight: …… Height: ……

Are any other people living at your address registered with this surgery? Yes / No

Do you smoke? Yes / No

If yes how many:
Cigarettes per day ……. Cigars per day …….. Ounces of tobacco per day ……..

Ex- smokers: How long ago did you stop smoking? ……

How much did you then smoke per day? ……

Are you exposed to smoking at home? Yes / No

Diet and Exercise

Does your daily diet include: **please tick**

5 Portions Fruit & Veg Meat or Protein Cereals Milk

Has your cholesterol level been checked in the last 2 yrs? Yes / No
Do you take regular exercise? Yes / No
If yes what sort of exercise? ……
How many times per week?

Family History

Has any member of your family (father, mother, brother, sister) suffered from any of the following before the age of 65yrs?

Heart disease (heart attack/angina)	Yes/No	Which family member?
Stroke	Yes/No	Which family member?
Cancer	Yes/No	Which family member?
Type of cancer (breast, lung, bowel etc)……..		
High blood pressure	Yes/No	Which family member?
Diabetes	Yes/No	Which family member?
Asthma	Yes/No	Which family member?

Medication

Please give name and dosage of any medication you take regularly (either prescribed or otherwise):

……

……

Allergies

Are you allergic to any medication, food, stings, animal fur or other substances Yes / No

If yes please give details …..……..

Current and Past Medical History…….

……

……

……

Immunisations
Please list if known……...
……

Date of last tetanus injection if known: ……..

Female Patients Only
Date and result of last cervical smear ……..

Contraceptive Pill Injection Coil Other
Please tick

How would you describe your Ethnic Origin Please tick

Asian	**Black**	**Mixed**
Asian British	Black British	Asian & White
Bangladeshi	African	Asian & Black
Indian	Caribbean	Asian & Black Caribbean
Pakistani	Sudanese	White & Black African
Other Asian background	Other Black background	White & Black Caribbean

White	**Other Ethnic Group**
British	Chinese
Irish	Turkish
Gypsy	Arab
Traveller	Japanese
Polish	Other ethnic group - please detail
Portuguese	
Any other White background	

I do not want to disclose my ethnic origin ☐

Is your first language English? Yes / No
If no please advise first language …….

In order to comply with the Equality Act 2010, GP Practices are now required to request the following information. This is in order to ensure we do our best to plan our services around the diverse needs of our patients.

Religion/Belief	**Please tick**	
Agnostic	Jainism	Do not wish to disclose ☐
Atheism	Judaism	
Buddhism	Pagan	
Christianity	Sikhism	
Hinduism	Other	
Islam	No particular faith	

Gender	**Please tick**	**Sexual Orientation**	
Male			
		Gay	
Female		Lesbian	
		Bisexual	
Transgender		Heterosexual	
		Do not wish to disclose	

Are You?	**Please tick**
Disabled	
Permanently Sick	
A Carer (unpaid)	

If you are a carer for someone who could not manage without your support and you do not receive any payment for it or have a carer, please ask Reception for details on help available

Alcohol Screening Tool

1 unit = ½ pt beer or 1 glass of wine or 1 single spirits

Please circle the answer which best applies to your drinking in the last year.

1. How often do you have a drink containing alcohol?

N/A Never (0) Monthly or less (1) 2-4 times a month (2)

2-3 times a week (3) 4 or more times a week (4)

2. How many units of alcohol do you drink on a typical day when you are drinking?

N/A 1 or 2 (0) 3 or 4 (1) 5 or 6 (2) 7 or 8 (3) 10 or more (4)

3. 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?

N/A Never (0) Less than monthly (1) Monthly (2)

Weekly (3) Daily or almost daily (4)

Patient Signature: …… **Date:**……

Office Use Only			System Input Date:
Type of ID:	Proof of Address:		
New Patient Medical Appointment:	Date:	Time:	Initials:

Jan-19

SMS Messaging/Email Service Terms and Conditions

By signing this agreement you are consenting for The Avenue Surgery to contact you via SMS message and/or email for the following reasons (when this service becomes available):

- Changes to your booked appointment
- To remind you of an appointment
- Cancelled clinics including GP, Practice Nurse and Health Care Assistant
- Practice being closed due to unforeseen circumstances
- Other notifications the practice deem necessary to your health care provision

Text and email messages are generated using a secure facility but please be aware that they are transmitted over a public network to your personal mobile/email address and as such may not be secure. However the practice will not transmit any information which would enable an individual patient to be identified nor will they contain any clinical information.

It is important you let us know if you change your mobile number or email address so that a) we have up to date contact details for you and b) we do not send texts or emails to a number/address that may no longer be yours.

If you share your mobile number/email address with another person you should be aware that they will be able to see communications sent from The Avenue Surgery.

Please note the surgery does not offer a reply facility to enable patients to respond to texts directly.

You can cancel the text message and/or email facility at any time. Please make a personal request to The Practice Manager and you will be opted out to the service within 48 hours.

Your mobile phone number and/or email address will only be used by The Avenue Surgery and will not be passed to any other parties.

As part of the registration process you will be required to show to a member of our reception staff a photo ID (passport or photo driving licence) in order to confirm your identity.

You can only apply for yourself and you must be 16 or over to register for this service.

The Avenue Surgery reserves the right to terminate this service (or part of it) without any notice.