Dr V Patel Surgery
9 Glanville Drive, Hornchurch, RM11 3SZ (01708 442117)
www.drvpatelsurgery.nhs.uk

In order to be fully registered with Dr V Patel, this form MUST be completed

NEW PATIENT HEALTH QUESTIONNAIRE (FOR ADULTS 16 YEARS +)					
TITLE:		**FIRST NAME:**			
SURNAME:					
DATE OF BIRTH:		**GENDER:**	**M** ☐ **F** ☐ (please tick)		
MARITAL STATUS:		**Preferred Language:**			
ADDRESS (incl flat no):		**ANY OTHER SURGERY PATIENTS LIVING AT THIS ADDRESS?**	**Please give names:**		
		ARE YOU A CARER FOR SOMEONE? **If yes, please specify:**	**YES** ☐ **NO** ☐ (please tick)		
HOME TEL:		**WORK TEL:**		**MOBILE TEL:**	
EMAIL ADDRESS:					
NEXT OF KIN: (Name, Address, Tel No.)					
ARE YOU HAPPY TO HAVE MESSAGES LEFT ON THE FOLLOWING NUMBERS?	**HOME TEL:**	**YES** ☐ **NO** ☐ (please tick)			
	MOBILE TEL	**YES** ☐ **NO** ☐ (please tick)			
Do you consent to allow the Practice to text you non-clinical information and reminders to your mobile number:		**YES** ☐ **NO** ☐ **(please tick)**			
OCCUPATION:					
HEIGHT:		**WEIGHT:**			

Pharmacy Details (name and address of preferred pharmacy)

Summary Care Record Consent		
Medication, allergies and adverse reactions only	**YES** ☐ **NO** ☐	(please tick)
Medication, allergies, adverse reactions and additional	**YES** ☐ **NO** ☐	(please tick)
Dissent – Patient does not want a summary care record	**YES** ☐ **NO** ☐	(please tick)

SMOKING HABIT				
Are you a current smoker?	**If Yes**		**If No**	
YES ☐ **NO** ☐ (please tick)	No. Cigarettes per day?		Have you ever smoked?	
	No. Cigars per day?		If yes, what year did you stop?	
	Pipe tobacco per week? (oz / grams)		How many *did* you smoke per day?	
	Would you like help to stop?	**YES** ☐ **NO** ☐		

ALCOHOL INTAKE	
Do you drink alcohol?	**YES** ☐ **NO** ☐ (please tick) **If Yes please complete the questionnaire below**

AUDIT C						
Questions	**Scoring System**					**Your Score**
	0	**1**	**2**	**3**	**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 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	
Total						

If your score is over 5 please continue:

AUDIT – remaining 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 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, 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	
Combined Total Score						

EXERCISE HABIT	
Do you take regular exercise?	**YES** ☐ **NO** ☐ (please tick)
If Yes: What sort : (eg. Tennis, walking)?	
For how long at any one time?	
How many times weekly?	

FAMILY HISTORY

Has a first degree relative (parent or sibling) suffered from any of the following conditions? (please tick)

Cancer	**YES** ☐ **NO** ☐	**Who?**		**At what age?**	
Stroke	**YES** ☐ **NO** ☐	**Who?**		**At what age?**	
Heart Disease	**YES** ☐ **NO** ☐	**Who?**		**At what age?**	
Diabetes	**YES** ☐ **NO** ☐	**Who?**		**At what age?**	

Do any other illnesses run in your family? YES ☐ **NO** ☐

If Yes, Please give details:

MEDICAL HISTORY

Do you have/have you had any of the following conditions? (please tick) **:**

High Blood Pressure (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐	**Diabetes** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐
Heart Disease (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐	**Angina** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐
Epilepsy (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐	**Stroke** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐
Asthma (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐	**Cancer** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐
If Asthmatic, have you used your inhaler in past 12 months?	**YES** ☐ **NO** ☐		

Please give details of any other illnesses, accidents, hospital admissions, investigations or operations you have had :

	Date:
	Date:
	Date:
	Date:

WOMEN ONLY

Date of Last Smear?		**What was the Result?**		**Where was it taken?**	
No. of Pregnancies?		**No. of Children?**		**Are you pregnant now?**	

MEDICATION	
ARE YOU ON ANY REGULAR MEDICATION? **(including the contraceptive pill)**	**YES** ☐ **NO** ☐ (please tick)
If Yes, please state name and dose or attach the most recent repeat reorder form (Please note you will be required to see the doctor for a first repeat prescription to be issued)	
ARE YOU ALLERGIC TO ANY MEDICINES?	**YES** ☐ **NO** ☐ (please tick)
If Yes, please state type and name:	

Over 65?	
Have you ever had a pneumonia vaccination?	**YES** ☐ **NO** ☐ (please tick)
Have you had a flu vaccine this year?	**YES** ☐ **NO** ☐ (please tick)

Do you have a disability? ☐ Yes ☐ No ☐ Decline to specify

The Disability Discrimination Act 1995 states 'a person has a disability for the purpose of this ACT if he/she has a physical or mental impairment, which has a substantial and long-term adverse effect on his/her ability to carry out day to day duties.

Ethnic Origin
This is not about nationality, place of birth or citizenship. It is about the group to which you perceive you belong. Please tick the appropriate box

White
English ☐ Welsh ☐ Scottish ☐ Northern Irish ☐ Irish ☐ British ☐ Prefer not to say ☐ Any other white background, please write in:

Mixed/multiple ethnic groups
White and Black Caribbean ☐ White and Black African ☐ White and Asian ☐
Prefer not to say ☐ Any other mixed background, please write in:

Asian/Asian British
Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese ☐ Prefer not to say ☐
Any other Asian background, please write in:

Black/ African/ Caribbean/ Black British
African ☐ Caribbean ☐ Prefer not to say ☐
Any other Black/African/Caribbean background, please write in:

Other ethnic group
Prefer not to say ☐ Any other ethnic group, please write in:

Do you need an interpreter or sign language support? **Yes** ☐ **No** ☐

Registration form checked and accepted by: _____

Date: _____/_____/_____

Patient Services

We offer an online service for our patients so you can book your appointments, order your repeat prescriptions and have online access to your medication history and allergies online at your convenience.

Online appointment booking

Have the flexibility to book and cancel your appointments from home, at work or any location with internet access. You don't need to queue at the practice, wait on the telephone and you can manage your appointments outside practice opening hours.

Request your repeat prescriptions online

Request your repeat prescriptions quickly online by logging into your account and simply ticking the appropriate boxes. You can review the progress of your repeat prescriptions and any message that the practice may have sent to you.

Access to your GP record online

Take greater control of your health and wellbeing by being able to view your medication history, allergies and adverse reactions online.

Dr V Patel Surgery

Patient Services - Patient registration form

To register please complete the form below and return it to the practice in person, **along with a valid form of identification (e.g. photo ID or your passport).** Once registered we will give you the information that will enable you to create a username and password.

Patient details	**Please complete in BLOCK CAPITALS**
Patient forename	
Patient surname	
Date of birth	D D / M M / Y Y Y Y
Email address **This email address will be used by your practice to send you notifications and reminders.**	
Mobile number	
Signature	
Date	D D / M M / Y Y Y Y
Completing the form on behalf of the patient?	
Print forename	
Print surname	
Relationship to patient	
Signature	
Date	D D / M M / Y Y Y Y

Staff use only	
Patient ID seen	
Type of ID	
Staff name	
Date	D D / M M / Y Y Y Y