

Patient's details

 Please complete in BLOCK CAPITALS and tick as appropriate

Mr Mrs Miss Ms Surname _____
 Date of birth _____ First names _____
 NHS No. _____ Previous surname/s _____
 Male Female Town and country of birth _____
 Home address _____
 Postcode _____ Telephone number _____

Please help us trace your previous medical records by providing the following information

Your previous address in UK _____ Name of previous GP practice while at that address _____
 Address of previous GP practice _____

If you are from abroad

Your first UK address where registered with a GP _____

If previously resident in UK, date of leaving _____ Date you first came to live in UK _____

Were you ever registered with an Armed Forces GP

 Please indicate if you have served in the UK Armed Forces and/or been registered with a Ministry of Defence GP in the UK or overseas:
 Regular Reservist Veteran Family Member (Spouse, Civil Partner, Service Child)

Address before enlisting: _____
 Postcode _____

Service or Personnel number: _____ Enlistment date: DD MM YY Discharge date: DD MM YY (if applicable)

Footnote: These questions are optional and your answers will not affect your entitlement to register or receive services from the NHS but may improve access to some NHS priority and service charities services.

If you need your doctor to dispense medicines and appliances*

- I live more than 1.6km in a straight line from the nearest chemist
 I would have serious difficulty in getting them from a chemist

*Not all doctors are authorised to dispense medicines

Signature of Patient Signature on behalf of patient
 Date ____ / ____ / ____

NHS Organ Donor registration

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.

- Any of my organs and tissue or
 Kidneys Heart Liver Corneas Lungs Pancreas

Signature confirming my consent to join the NHS Organ Donor Register _____ Date ____ / ____ / ____

 Please tell your family you want to be an organ donor. If you do not want to be an organ donor, please visit www.organdonation.nhs.uk or call 0300 123 23 23 to register your decision.

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 donate blood.

 Tick here if you have given blood in the last 3 years

Signature confirming my consent to join the NHS Blood Donor Register _____ Date ____ / ____ / ____

My preferred address for donation is: (only if different from above, e.g. your place of work) _____

Postcode: _____

 All blood types are needed, especially O negative and B negative. Visit www.blood.co.uk or call 0300 123 23 23.

 NHS England use only Patient registered for GMS Dispensing

To be completed by the GP Practice

Practice Name

Practice Code

I have accepted this patient for general medical services on behalf of the practice

I will dispense medicines/appliances to this patient subject to NHS England approval.

Signature to the best of my/our/their administrative knowledge

Authorised Signature

Name

Date ____/____/____

Practice Stamp

SUPPLEMENTARY QUESTIONS - These questions and the patient declaration are optional and your answers will not affect your entitlement to register or receive services from your GP.

PATIENT DECLARATION for all patients who are not ordinarily resident in the UK

Anybody in England can register with a GP practice and receive free medical care from that practice. However, if you are not 'ordinarily resident' in the UK you may have to pay for NHS treatment outside of the GP practice. Being ordinarily resident broadly means living lawfully in the UK on a properly settled basis for the time being. In most cases, nationals of countries outside the European Economic Area must also have the status of 'indefinite leave to remain' in the UK. Some services, such as diagnostic tests of suspected infectious diseases and any treatment of those diseases are free of charge to all people, while some groups who are not ordinarily resident here are exempt from all treatment charges. More information on ordinary residence, exemptions and paying for NHS services can be found in the Visitor and Migrant patient leaflet, available from your GP practice.

You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment. Even if you have to pay for a service, you will always be provided with any immediately necessary or urgent treatment, regardless of advance payment.

The information you give on this form will be used to assist in identifying your chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitals) and NHS Digital, for the purposes of validation, invoicing and cost recovery. You may be contacted on behalf of the NHS to confirm any details you have provided.

Please tick one of the following boxes:

- a) I understand that I may need to pay for NHS treatment outside of the GP practice
- b) I understand I have a valid exemption from paying for NHS treatment outside of the GP practice. This includes for example, an EHIC, or payment of the Immigration Health Charge ("the Surcharge"), when accompanied by a valid visa. I can provide documents to support this when requested
- c) I do not know my chargeable status

I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

A parent/guardian should complete the form on behalf of a child under 16.

Signed:		Date:	DD MM YY
Print name:		Relationship to patient:	
On behalf of:			

Complete this section if you live in another EEA country, or have moved to the UK to study or retire, or if you live in the UK but work in another EEA member state. Do not complete this section if you have an EHIC issued by the UK.

NON-UK EUROPEAN HEALTH INSURANCE CARD (EHIC), PROVISIONAL REPLACEMENT CERTIFICATE (PRC) DETAILS and S1 FORMS

Do you have a non-UK EHIC or PRC?	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	If yes, please enter details from your EHIC or PRC below:
<p>If you are visiting from another EEA country and do not hold a current EHIC (or Provisional Replacement Certificate (PRC))/S1, you may be billed for the cost of any treatment received outside of the GP practice, including at a hospital.</p>	Country Code: <input type="text"/>	
	3: Name	
	4: Given Names	
	5: Date of Birth	DD MM YYYY
	6: Personal Identification Number	
	7: Identification number of the institution	
	8: Identification number of the card	
	9: Expiry Date	DD MM YYYY
	PRC validity period (a) From:	DD MM YYYY

Please tick if you have an S1 (e.g. you are retiring to the UK or you have been posted here by your employer for work or you live in the UK but work in another EEA member state). Please give your S1 form to the practice staff.

How will your EHIC/PRC/S1 data be used? By using your EHIC or PRC for NHS treatment costs your EHIC or PRC data and GP appointment data will be shared with NHS secondary care (hospitals) and NHS Digital solely for the purposes of cost recovery. Your clinical data will not be shared in the cost recovery process.

Your EHIC, PRC or S1 information will be shared with The Department for Work and Pensions for the purpose of recovering your NHS costs from your home country.

Initials of staff member taking registration: _____ Your named GP is **Dr. Nick Mann**

WELL STREET SURGERY HEALTH QUESTIONNAIRE FOR NEW PATIENTS AGED 16+

It would help us greatly if you are able to give detailed information about yourself. All information you give us will be kept confidential. Some general information, such as the number of patients in different ethnic groups and the number of patients that smoke is used by the Health Authority to plan services, but it is always anonymised data and no names are attached to it.

Please continue on a separate sheet if you need more space. Leave blank any question you do not wish to answer.

Forename(s): _____ Surname: _____

Date of Birth: _____ Age: _____

Home Telephone No. _____ Work Telephone No. _____

Mobile No. _____

E-mail: _____

	Yes	No
Do you wish to be contacted via text.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you wish to be contacted via email	<input type="checkbox"/>	<input type="checkbox"/>
Do you wish to become a member of our Patient Participation Group (PPG).....	<input type="checkbox"/>	<input type="checkbox"/>

Employment Status: Employed Unemployed Student
(Please tick a box)
 Retired Full time parent

Please state your usual occupation: _____

To which ethnic group would you say you belong?

White – English, Scottish, Welsh	<input type="checkbox"/>	Black African	<input type="checkbox"/>
White - Irish	<input type="checkbox"/>	Black British	<input type="checkbox"/>
White – Other (please specify)	<input type="checkbox"/>	Black Caribbean	<input type="checkbox"/>
_____		North African	<input type="checkbox"/>
Traveller	<input type="checkbox"/>	Indian	<input type="checkbox"/>
Greek or	<input type="checkbox"/>	Bangladeshi	<input type="checkbox"/>
Greek Cypriot	<input type="checkbox"/>	Pakistani	<input type="checkbox"/>
Turkish or	<input type="checkbox"/>	Vietnamese	<input type="checkbox"/>
Turkish Cypriot	<input type="checkbox"/>	Orthodox Jew	<input type="checkbox"/>
Kurdish	<input type="checkbox"/>	Do not wish to state	<input type="checkbox"/>

Other than these please specify: _____

What is your first language? _____

If not English, do you require an interpreter? Yes No

The Disability Discrimination Act 1995 (DDA) defines a person as disabled if they have a physical or mental impairment, which has a substantial and long term effect (i.e. has lasted or is expected to last at least 12 months) on the person's ability to carry out normal day-to-day activities.

Do you consider yourself to have a disability according to the terms given in the DDA?

Yes No Prefer not to say

Do you have any additional information and communication needs due to disability, impairment or sensory loss?

Braille Easy Read

Large text BSL interpreter

Other Please specify.....

Optional questions – patients do not need to answer

Gender

Male Transgender
 Female Prefer not to say

Religion/Beliefs

Buddhism Sikhism
 Christianity No religion
 Hinduism Other (specify if you wish)
 Islam Prefer not to say
 Judaism

Sexual Orientation

Bi-sexual Other (specify if you wish)
 Heterosexual/straight Prefer not to say
 Gay Patient is under 16
 Lesbian

YOUR HEALTH

Are you on any regular medication?

Yes

No

If yes, please make an appointment with a GP before your next prescription is due. Please bring with you either all your medication, or the list of medication issued by your last doctor.

Please tick the box if you have ever had:

Diabetes

High blood pressure

Asthma

Heart attack

If you have ticked any of the above, we strongly recommend that you have a health check with the nurse. Please speak to the receptionist to make an appointment.

Please tick as appropriate:

Never smoked

Current smoker

How many per day? _____

Ex smoker

Date when you stopped? _____

How tall are you? _____ ft _____ ins or _____ cms

How much do you weigh? _____ st _____ lbs or _____ kgms

How often do you take exercise? _____ time(s) per week

YOUR FAMILY'S HEALTH

Is there anyone in your immediate family (parents, brothers, sisters, grandparents) suffering from any of the following?

Diabetes

Stroke before the age of 55

High blood pressure

High cholesterol

Heart attack before the age of 55

Breast cancer

Angina before the age of 55

If yes, please make an appointment to see a nurse.

For WOMEN only:

When and where did you last have a cervical smear?

When? _____

Where? _____

What was the result? (i.e. normal, virus infection, inflammation, etc) _____

Alcohol

Because alcohol use can affect your health and interfere with certain medications and treatments, we would like to ask you some questions about your use of alcohol.

Please complete the questions below and enter your score

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink that contains alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many standard drinks do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

YOUR TOTAL SCORE

If you have scored below 5 your drinking is within safe limits. Please move to page 5.

If you have scored 5 or above you may be at an increased risk of health problems due to drinking and we would recommend that you complete the more detailed questionnaire on page 5.

Please complete if you have scored 5 or above on the alcohol questionnaire on page 4...

This is one unit of alcohol...



Half pint of regular beer, lager or cider



1 small glass of wine



1 single measure of spirits



1 small glass of sherry

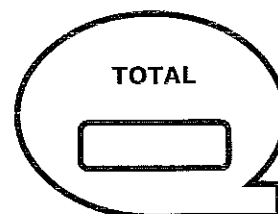


1 single measure of aperitifs

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 drinks containing alcohol do you have on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 9	10+	
How often do you have six or more drinks on one occasion? Skip to questions 9 & 10 if total score for questions 2 & 3 = 0	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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 a first 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 Sensible drinking, 8 - 15 hazardous drinking, 16 - 19 Harmful drinking, 20+ possible dependence

If you have scored over 7, please make an appointment with our HCA, Practice Nurse or Alcohol Counsellor



TUBERCULOSIS (TB) SCREENING

For Under 35s

Are you a new entrant from any of the following areas?

Africa, Eastern Europe (including Turkey and the Balkans) Asia, Middle and Far East

Yes No

If yes, please make an appointment to see the nurse about TB screening.

Have you been in contact (lived/shared close space) with someone with TB in the last 5 years?

Yes No

If yes, please make an appointment to see the nurse about TB screening.

Do you have any symptoms of TB i.e. cough, malaise, fever, night sweats, weight loss, enlarged glands?

Yes No

If yes, please make an appointment to see a doctor.

For Over 35s

Have you been in contact (lived/shared close space) with someone with TB in the last 5 years?

Yes No

If yes, please make an appointment to see a doctor.

Do you have any symptoms of TB i.e. cough, malaise, fever, night sweats, weight loss, enlarged glands?

Yes No

If yes, please make an appointment to see a doctor.

Pharmacy Nomination

Would you like your prescriptions to be directed to a specific local pharmacy?

.....

If not, prescriptions will be directed to **Sonigra Pharmacy**, 44 Well St, Hackney, London E9 7PX

Important Information:

Communication

For your convenience, we routinely send texts to our patients regarding appointments, and may occasionally text you with updates to our services. Please tick the box on the first page if you would prefer for us not to do so.

SCR (Summary Care Record) Preferences

A summary care record is a small record of information that is available to other health professionals who are involved in your care, should they need it. It contains the following information: your name, address, date of birth, NHS number, medications that you are taking, any bad reactions to medicines that you may have had in the past and any allergies that you have.

If you would not like an SCR to be created, please ask reception for an opt-out form, otherwise an SCR will automatically be created for you. If you would like any more information on the subject, please ask reception for a leaflet.

Teaching

Well Street Surgery is proud to be a teaching practice working in conjunction with Barts and the London School of Medicine and King's College London, and as such, will have medical students in the surgery from time to time.

You will always be notified of the student's presence before your consultation and have the right to refuse their presence at any point.

NHS Health Checks

An NHS Health Check is available to all patients aged 40 and above, who have not had one in the previous 5 years and who do not have any current long-term conditions (e.g. diabetes, asthma). Please speak to reception to make an appointment with our Health Care Assistant.

Name: _____ Signed: _____ Date: _____

