**Jubliee Surgery**

**First Floor, Whitton Corner Health & Social Care, Percy Road, Whitton TW2 6JL**

Telephone : 0203 405 0840

**New Patient Registration**

**About you**

Surname: ………………………………………………………………………………….……

Forename(s): …….……………………………………………………………………….……

Date of Birth (dd/mm/yyyy): ………………. NHS number (if known): ………….…..

Gender: ……………………………………

**Contact Information**

Address:………………………………………………………………………………………………………

…………………………………………………………………………………………………………………

Telephone: …………………………… Mobile: …………………………………………

Email: ………………………………………………

Please **circle** below your preferred choice of contact: **Text Phone Email Post**

Do you live in a residential home? **Yes**  **No**

Do you live in a nursing home? **Yes No**

Would you describe yourself as homeless? **Yes**   **No**

What is your Occupation?........................................................................................................

**Residency**

Previous address in the UK (if applicable):………………………………………………………….

**Service Families and Military Veterans**

As a practice, we fully support the Armed Forces Covenant. We can only do this if we know our patients’ connections to the Armed Forces. Please tick the below boxes that apply to you:

|  |  |  |  |
| --- | --- | --- | --- |
| **I AM** a Military Veteran |  | **I AM** currently serving in the Reserve Forces |  |
| **I AM** married/civil partnership to a serving member of the Regular/Reserve Armed Forces |  | **I AM** married/civil partnership to a Military Veteran |  |
| **I AM** under 18 and my parent(s) are serving member(s) of the armed forces. |  | **I AM** under 18 and my parent(s) are veteran(s) of the armed forces. |  |

**Asylum Seekers**

Are you classed as an Asylum seeker? **YES** **NO**

If so, please indicate your country of origin:……………………………………………

**Ethnicity**

Having information about patients’ ethnic groups would be helpful for the NHS so that it can plan and provide culturally appropriate and better services to meet patients’ needs.

If you do not wish to provide this information you do not have to do so.

Please indicate your ethnic origin by ticking the below box:

|  |  |  |  |
| --- | --- | --- | --- |
| Asian/British Asian: Chinese |  | Mixed ethnic: Black Caribbean/White |  |
| Asian/British Asian: any other Asian background |  | Mixed ethnic White/Asian |  |
| Asian/British Asian: Bangladeshi |  | Mixed multiple ethnic background |  |
| Asian/British Asian: Indian |  | Other ethnic group |  |
| Asian/British Asian: Pakistani |  | White: English/Welsh/Scottish/N. Ireland |  |
| Black/African/Caribbean/Black British |  | Other ethnic group Arab |  |
| Mixed ethnic: Black African/White |  | White Irish |  |
| White: any other white background |  | White Gypsy / Traveller |  |

**Preferred title**

How would you like us to refer to you (eg Mr, Mrs, Miss, Mx)?.................................

**Religious affiliation**

Do you have a religious affiliation (please give details if so)?...................................

**Country of birth**

In which country were you born?...........................................................

If you are from abroad, what date did you come to UK?..........................................

**Main language**

Which is your main language?.................................................................

Do you speak English?.............................................................................

Do you need an interpreter? **Yes No**

If so, which language? …………………………………………

**Carer status**

Do you have a carer? **Yes No**

**If Yes, please give details of their name, relationship and whether they are a patient here too……………………………………………………………………………………**

Do you give consent to contact your carer about your care? **Yes No**

Are **you** yourself a carer? **Yes No**

**Next of kin**

Surname: …………………………………… Forename(s): …………………………………………

Gender: ……………………………………

**Relationship to you………………………. Can they speak on your behalf? Yes/no**

Telephone: ……………………………………… Mobile: ……………………………………………

**Would you like to a member of our Parent Participation Group (PPG) yes/no**

**Contacting you**

**We will use your contact details to send reminders about appointments, reviews and other services which may be of benefit in your medical care**

Do you consent to the Surgery sending letters to your home address? **Yes No**

Do you consent to the Surgery sending text messages to your mobile? **Yes No**

Do you consent to the Surgery sending messages to you by email? **Yes No**

Do you consent to the Surgery leaving messages on your phone? **Yes No**

(We will not leave detailed messages on your phone, but may ask you to contact us or leave a simple message if we do not need to speak to you).

**Are you interested in joining our Patient Participation Group (PPG)?** **Yes No**

**Summary Care Record** (SCR)

**If you decide to have a SCR, it will contain important information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines that you have had it will also include basic information about your current diagnoses**. Giving healthcare staff access to this information can prevent mistakes being made when caring for you in an emergency or when your GP practice is closed. Your Summary Care Record will also include your name, address, date of birth and your unique NHS Number to help identify you correctly. If you and your GP decide to include more information it can be added, but only with your express permission

**For more information**: visit <https://digital.nhs.uk/services/summary-care-records-scr>

**I WANT to have a Summary Care Record**

**I do not wish to have a Summary Care Record**

(N.B. this will mean NHS Healthcare staff caring for you may not be aware of your current medications, any allergies or reactions to previous medication.)

**Local Shared Electronic Health Record**

Many areas of the country have a local shared electronic health record too. Giving healthcare staff access to this information can prevent mistakes being made when caring for you in an emergency or when your GP practice is closed. Are you happy for your record to be shared across organisations caring for you? (this is accessed by relevant staff for your direct care on a need-to-know basis only)

Are you happy to be part of the local shared electronic health care record?

**(if you select no, you need to be aware that NHS Healthcare staff may not be able to see important elements of your care history**)

**Yes No**

**Electronic Prescribing Service (EPS)**

The EPS allows prescribers – such as GPs and practice nurses to send prescriptions electronically to a dispenser (such as a pharmacy) of the patient’s choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff. As a practice, we would encourage all patients to opt for electronic prescribing.

**I DO** give consent for my prescriptions to be sent electronically to the pharmacy

**I DO NOT** give consent for my prescriptions to be sent electronically to the pharmacy

Nominated pharmacy……………………………………………………………………………………

**Smoking status**

Do you smoke?

**If yes,** **how many** cigarettes do you smoke daily: …**……………**

If no**,** have you smoked in the past? **Yes**

Do you use electronic cigarettes/vape? **Yes No**

*If you would like help and advice on how to give up smoking,*

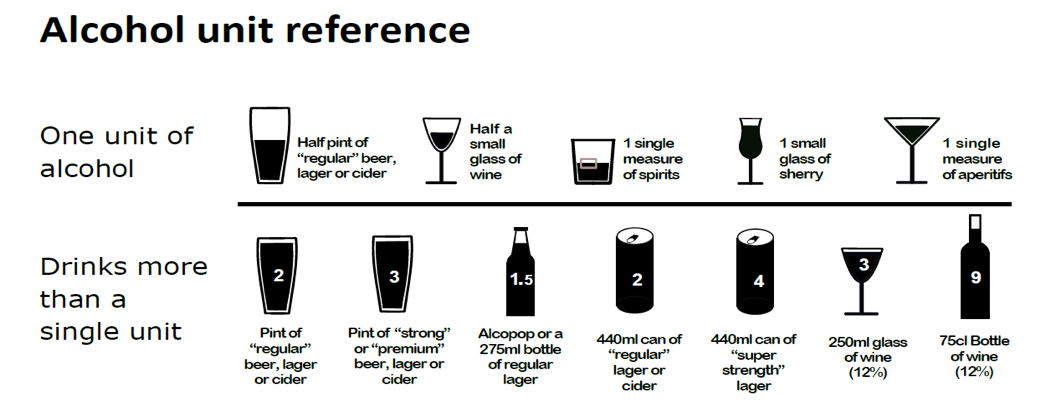
*please contact* [*https://www.nhs.uk/live-well/quit-smoking/*](https://www.nhs.uk/live-well/quit-smoking/) *or ask at reception.*

**For female patients only**

Are you currently pregnant? **Yes No**

***If yes,*** *please ensure you are under the care of a midwife. If you’re not currently under the care of a midwife please speak to reception regarding this.*

**Alcohol intake**



|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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 alcoholic 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 |  |

**Scoring** Score: ……………….

*A total of 5+ indicates increasing or higher risk drinking. If you have a score of 5+ please complete the remaining questions below.*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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 |  |
| **Questions** | **Scoring system** | | | | | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| 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 |  |

Please add up your scores from the above tables and write the total below:

**Total**…………………………..

*If you would like help and advice on how to reduce your alcohol intake, please contact* [*https://www.drinkaware.co.uk/*](https://www.drinkaware.co.uk/) *or ask at reception.*

**Exercise**

**General Practice Physical Activity Questionnaire**

Please tell us the type and amount of physical activity involved in your work.

|  |  |  |
| --- | --- | --- |
|  |  | **Please mark one box only** |
| a | I am not in employment (e.g. retired, retired for health reasons, unemployed, fulltime carer etc.) |  |
| b | I spend most of my time at work sitting (such as in an office) |  |
| c | I spend most of my time at work standing or walking. However, my work does not require much intense physical effort (e.g. shop assistant, hairdresser, security guard, childminder, etc.) |  |
| d | My work involves definite physical effort including handling of heavy objects and use of tools (e.g. plumber, electrician, carpenter, cleaner, hospital nurse, gardener, postal delivery workers etc.) |  |
| e | My work involves vigorous physical activity including handling of very heavy objects (e.g. scaffolder, construction worker, refuse collector, etc.) |  |

1. During the *last week*, how many hours did you spend on each of the following activities? *Please answer whether you are in employment or not*

**Please mark one box only on each row**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | **None** | **Some but less than 1 hour** | **1 hour but less than 3 hours** | **3 hours or more** |
| a | Physical exercise such as swimming, jogging, aerobics, football, tennis, gym workout etc. |  |  |  |  |
| b | Cycling, including cycling to work and during leisure time |  |  |  |  |
| c | Walking, including walking to work, shopping, for pleasure etc. |  |  |  |  |
| d | Housework/Childcare |  |  |  |  |
| e | Gardening/DIY |  |  |  |  |

1. How would you describe your usual walking pace? **Please mark one box only.**

|  |  |  |
| --- | --- | --- |
|  | Steady average pace  Fast pace  (i.e. over 4mph) |  |
|  |  |

Slow pace (i.e. less

than 3 mph)

Brisk pace

**Disabilities / Accessible Information Standards\_**

**As a practice we want to make sure that we give you information that is clear to you. For that reason we would like to know if you have any communication needs.**

Do you have any special communication needs?

**Yes No**

**If yes,** please state your needs below:

**………………………………………………………………………………..**

Do you have significant mobility issues? **Yes No**

**If yes,** are you housebound? **Yes No**

*(Definition of housebound - A patient is unable to leave their home due to physical or psychological illness)*

Are you blind/partially sighted? **Yes No**

Do you have significant problems with your hearing? **Yes No**

**Family History and past medical history**

Have any close relatives (parent, sibling or child only) ever suffered from any of the following?

|  |  |  |
| --- | --- | --- |
| Condition | Yes | No |
| Heart Disease (Heart attack/Angina) |  |  |
| Stroke |  |  |
| Diabetes |  |  |
| Asthma |  |  |
| Cancer |  |  |

Have you yourself ever suffered from any important medical illness, operation or admission to hospital? **If so** please enter details below:

|  |  |  |
| --- | --- | --- |
| **Condition** | **Year diagnosed** | **Ongoing?** |
|  |  |  |
|  |  |  |
|  |  |  |

**Allergies**

Please list any drug or food allergies that you have:

…………………………………………………………………………………………………………………

**Medications**

Please provide a list of repeat medications:………………………………………..……………….

…………………………………………………………………………………………………..…………….

…………………………………………………………………………………………………………………