New Patient Registration Questionnaire for Adults

Welcome to Hillview Surgery. Thank you for taking time to complete this questionnaire in **BLOCK CAPITALS**

PERSONAL DETAILS	Have you previously been registered at this practice before? YES ☐ NO ☐
Please circle: Mr / Mrs / Miss / Ms / Dr / Other: Surname: First name:	
Address: Postcode:	Date of Birth: / / Occupation:
Home Tel:	Mobile:
Email:	NHS No.
Main Language (if not English):	Do you need an interpreter? YES ☐ NO ☐
Town of Birth:	Country of Birth:
Preferred method of contact?	Telephone: (Home) ☐ (Mobile) ☐ Letter ☐ Email ☐
Do you consent to us contacting you by SMS text message	YES ☐ NO ☐

Are you over 40 Years of Age?	YES ☐ NO ☐ If Yes, please book an appointment with a Health Care Assistant for an NHS Health Check

ETHNIC ORIGIN	**Please tick one box only**		
☐ White British	☐ White Irish	☐ White Gypsy or Irish Traveller	☐ Other White (Specify)……
☐ Arab	☐ Bangladeshi	☐ Black African	☐ Black Caribbean
☐ Chinese	☐ Indian	☐ Pakistani	☐ Mixed White & Asian
☐ Mixed White & Black African	☐ Mixed White & Black Caribbean	☐ Other Asian (Specify)……	☐ Other Black (Specify)……
☐ Other Mixed (Specify)……	☐ Other Ethnic (Specify)……	☐ I do not wish to answer this question	

NEXT OF KIN	Name: Relationship to you: Next of Kin Telephone Number:

CARERS	Are you looking after someone? YES ☐ NO ☐ Let us know if you are looking after someone who is ill, frail, disabled or has mental health/and or emotional support needs or substance misuse problems
	Is someone looking after you? YES ☐ NO ☐ Let us know if a family member, friend or neighbour looks after you. If yes they are your carer. You are welcome to invite your carer to accompany you when you visit the practice.
Name of Carer: Relationship to you: Address of Carer: Telephone Number of Carer:	

MEDICAL HISTORY	**Please tick if you have ever suffered or been treated for any of the following:**				
☐ Asthma	☐ Epilepsy	☐ Diabetes	☐ High Cholesterol	☐ Mental Illness	☐ Cancer of:
☐ COPD	☐ Stroke	☐ High BP	☐ Heart Disease	☐ Thyroid Disorder	☐ Other:

FAMILY HISTORY	**Please state if any family member has suffered from any of the conditions listed above:**
Illness/Condition	
Family Member	
Age Diagnosed	

MEDICATION	Are you taking regular medication? YES ☐ NO ☐
	If Yes, please book an appointment with a Health Care Assistant before you need to request medication. Please bring your repeat medication request slip from your previous GP to your appointment with you. If you do not have this please bring a list of your medication and the packaging.
	Do you have any allergies to drugs or medication? YES ☐ NO ☐
	Please specify:

Please list any medication you are currently taking below:

VACCINATIONS	Please provide copies of any vaccinations you have received. If these are in a foreign language please provide a translation into English.

FEMALE PATIENTS ONLY	Are you currently pregnant? YES ☐ NO ☐
If yes, please book an appointment with a doctor	
If aged 25-64 years old what is the date of your last Cervical Smear Test? Where was it done? What was the result?	
Have you had a hysterectomy? YES ☐ NO ☐	

LIFESTYLE	Height (approx.)?	Weight (approx.)?

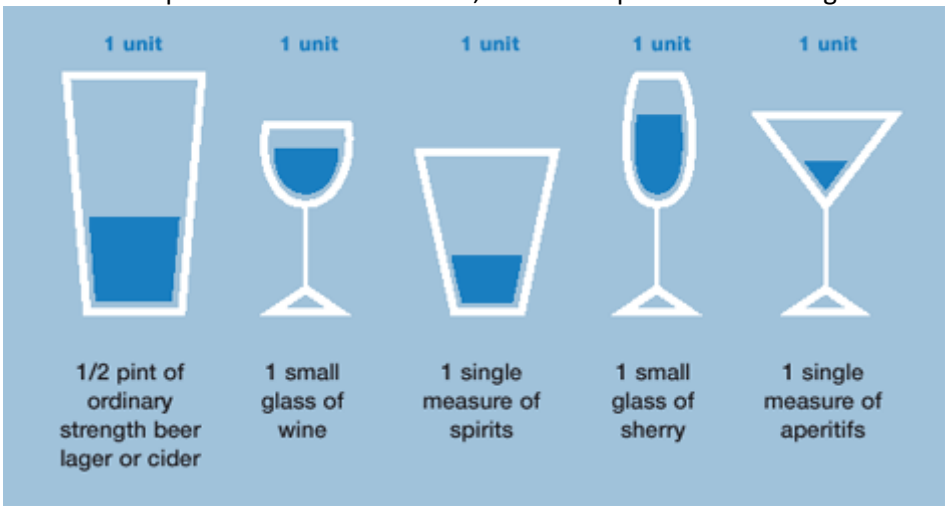
Smoking Habits ☐ Never Smoked ☐ Ex-Smoker, Stopped (year) - Amount when gave up - ☐ Currently Smoke Please state the amount a day and type (cigarette, cigar, pipe etc.)

……

If you would like to stop smoking, please ask reception for details of Smoking Cessation Services.

ALCHOHOL

Alcohol consumption is measured in units, which is explained in the diagram below.



Please use this diagram for your answers below

Do you Drink YES ☐ NO ☐ / If **YES** how many Drinks per week in Units: Beer …….. / Wine …… / Spirits …….

RECORD SHARING

Medical Record Sharing

Hillview Surgery, 179 Bilton Road, Perivale, Greenford UB6 7HQ – Tel: 020 8997 4661, Fax: 020 8810 8015

Medical Record Sharing allows your complete GP medical record to be made available to authorised healthcare professionals involved in your care. You will always be asked your permission before anyone looks at your shared medical record.

An informed patient, in consultation with a Health Care Professional, can choose to permit or restrict access to the information entered into their clinical record at each SystmOne organisation at which they receive care. The patients consent can be changed at any time.

SHARING OUT

Does the patient consent to the sharing of data recorded here with any other organisation that may care for the patient?

☐ YES – share data with other organisations

☐ NO – do not share any data recorded here

SHARING IN

Does the patient consent to viewing of data by this organisation that is recorded at other care services that may care for the patient where the patient agreed to make the data shareable?

☐ CONSENT GIVEN

☐ CONSENT REFUSED

Name …….

Signature …….

Date …….

CHECKLIST		
Thank you for completing this form. Please check you have completed all sections where possible. Please ensure that you bring the following with you to the surgery to complete your registration.		
1.	Completed & Signed New Patient Registration Questionnaire (this form)	☐
2.	Completed and Signed GMS1 Form	☐
3.	Photo Proof of ID – e.g. Passport, Photo Driving Licence or Photo ID Card	☐
4.	Proof of Address – This must be in your name and dated within the past 3 months • Please use one of the following: Bank Statement, Utility Bill (Gas, Water, electric), Council Tax, Tenancy Agreement or Landlord Phone Bill (**MOBILE PHONE BILLS ARE NOT ACCEPTED**)	☐
5.	If possible, your Immunisation Records – usually the Personal Child Health Record (Red Book)	☐
6.	If possible, your NHS Card – usually shows your previous GP and your NHS number	☐
7.	If relevant, your repeat Medication Request Slip from your previous GP	☐

Remember to book an appointment with a Healthcare Assistant if the following apply to you:

- **You have any chronic or significant medical condition**
- **You are on regular medication including the Pill or HRT**
- **You are over 40 years of age**

Please request a copy of the Practice Leaflet if you have not already received it. Alternatively you can also find more information at www.hillviewsurgery.nhs.uk

WE MAINTAIN THE RIGHT TO REMOVE PATIENTS FROM OUR LIST WHO DISPLAY UNACCEPTABLE BEHAVIOUR OR VIOLENCE TOWARDS STAFF OR OTHER PATIENTS

I confirm that I have completed this form as accurately and honestly as possible and would like to apply to be registered as a patient at this practice

Signature …….. Date: / / 20....

OFFICIAL USE ONLY	Does the patient need an appointment? YES ☐ NO ☐ Staff Initials:			
Photo ID	☐ Passport	☐ Driving Licence	☐ Identity Card	☐ Other
Proof of Address	☐ Utility Bill	☐ Tenancy Agreement	☐ Bank Statement	☐ Other
Comments:				