Date: .....

New Patient Health Questionnaire

Dear Patient,

Thank you for registering with The Pembridge Villas Surgery. As it may be some time before your previous records arrive at this practice we would therefore be grateful if you could answer the following questions. This will give us a better idea about your health, and help us to look after you. Please email both forms with a copy of ID and proof of address to ***pembridge.registrations@nhs.net***

*Personal Details (PLEASE USE CAPITALS)

First Name		**Surname**		
Date of Birth		**Sex**	Male ☐	Female ☐
Address				
City + Postcode				
Telephone		**Mobile Phone**		
Occupation		**Email**		
Country of Birth		**First Language**		

English Speaker: Yes ☐ No ☐ Do you require an **interpreter?** Yes ☐ No ☐

Ethnic Origin *The classification is entirely voluntary but will help us to provide a better service. The level of care you will be offered at this practice will not be affected by decision to complete this.*

Please tick most appropriate:

☐	White British	☐	Bangladeshi	☐	Other Black
☐	White Irish	☐	Chinese	☐	Black African + White
☐	White Other	☐	Other Asian Ethnic Group	☐	Other Ethnic – Asian/White Origin
☐	Mixed Pakistani	☐	Black African	☐	Black Caribbean + White
☐	Mixed Indian	☐	Black Caribbean/West Indian/Guyana	☐	Other Ethnic Group

Are you a refugee or are you seeking political asylum in the UK? Yes ☐ No ☐

Next of kin (Name): .....Relationship: .....

Next of kin telephone number: .....

*Accessibility Information

Do you need help with mobility/hearing/speaking? Yes ☐ No ☐

(Please tick all that apply)

☐	Wheelchair	☐	Walking Aid	☐	Hearing Aid
☐	British Sign Language	☐	Makaton Sign Language	☐	Lip Reading
☐	Large Print	☐	Braille	☐	Easy To Read
☐	Other : *Please state*				

*** Flu Vaccination** **Have you had your flu vaccine this year?** Yes ☐ No ☐

When? (Month) ..... **Where?** Pharmacy ☐ Private GP ☐

Other: .....

Nominated GP (To be filled in by Clinician)	
XacWQ	*Patient allocated named accountable general practitioner*
Xab9D	*Informing patient of named accountable general practitioner*

*Medical History

Please state current:

Height:	**Weight:**	**Blood pressure:**

Do you suffer or have suffered from any of the following conditions, if yes since when?

Heart Disease	Yes	☐	No	☐	Since:
Stroke	Yes	☐	No	☐	Since:
Cancer (Which type?)	Yes	☐	No	☐	Since:
Diabetes (Which type?)	Yes	☐	No	☐	Since:
Asthma	Yes	☐	No	☐	Since:
High blood pressure	Yes	☐	No	☐	Since:
Epilepsy	Yes	☐	No	☐	Since:
High Cholesterol	Yes	☐	No	☐	Since:

*Please list any other **serious illness, operations or accidents** you had in the past (give dates when possible).

……

……

*Please list any **medicines/tablets** you are currently taking

……

……

***Eligibility criteria for LTBI Screening**

Are you age 16-35 Yes ☐ No ☐

Where you Born or spent > 6 months in High TB incidence country? Yes ☐ No ☐

If yes, which Country: …….. *(If unsure please ask reception/check website for list of Countries)*

Have you come to this country in the last 5 years? Yes ☐ No ☐

Have you been tested for Tuberculosis (TB) infection? Yes ☐ No ☐

Have you had a BCG vaccine? Yes ☐ No ☐ Unknown ☐

(You may be eligible for a screening test and the nurse will discuss this further if needed.)

***Do you have any allergies?** Yes ☐ No ☐

Please list.....

***Lifestyle**

Smoking status: **Never smoked:** ☐ **Ex-smoker:** ☐ **Current Smoker:** ☐

If current smoker: Year when you started: …… Average cigarettes per day: ……

If ex-smoker: Year when you stopped: …… Average cigarettes per day: ……..

What regular **exercise** do you take? How many days a week?

……

……..

***Family Medical History**

Has a member of your immediate family (father, mother, siblings, and grandparents) had or suffered from any of the following? If 'Yes', Please state relationship and condition.

		Relationship *(Paternal or Maternal side)*	Which type?
Heart attack	Yes ☐ No ☐		
Stroke	Yes ☐ No ☐		
Cancer (Type?)	Yes ☐ No ☐		
Diabetes (Type?)	Yes ☐ No ☐		
High blood pressure	Yes ☐ No ☐		
Other	Yes ☐ No ☐		

***Chlamydia screening**

I would like to do the test ☐ I do not want to do the test ☐ I need to speak to the nurse ☐

(*Please leave a urine sample at reception)*

***Female Patients Only**

	Yes	No	If Yes, When + Where	NHS or Private?
Have you ever had a cervical smear?	☐	☐		☐ ☐
What was the Result?				
Advised Recall time?	3 mths ☐	6 mths ☐	1 Year ☐ 3 Years ☐ 5 Years ☐	
Have you had a hysterectomy?	☐	☐	If yes, when?	
Are you using any contraception?	☐	☐	If Yes, what method?	

***Carers**

Do you care for a vulnerable person (adult or child) Yes ☐ No ☐

Their Name and Contact Details .....

Kensington and Chelsea recognise that informal carers provide an invaluable service. In partnership with the RBKC they are keen to ensure that carers are provided with all available support and information to assist them.

***Alcohol Screening Questionnaire**

Do you **drink alcohol**? Yes ☐ No ☐

How **many units a week**? .....
(Wine: 125ml glass = 1.5 units, 175ml glass = 2.0 units; 250ml glass = 3units, pint of lower strength lager/beer/cider = 2 units; pint of higher strength lager/beer/cider = 3 units; single small shot of spirit = 1 unit)

Please tick the most relevant box for each question.

	SCORE				
Alcohol Screening Questions	**0**	**1**	**2**	**3**	**4**
1. How often do you have a drink containing alcohol?	☐ Never	☐ Monthly or less	☐ 2-3 Times a month	☐ 2-3 Times a week	☐ 4 Or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	☐ 1 or 2	☐ 3-4	☐ 5-6	☐ 7-8	☐ 10 or more
3. How often during the last year have you found that you were not able to stop drinking once you started?	☐ Never	☐ Less than monthly	☐ Monthly	☐ Weekly	☐ Daily or almost daily
4. How often during the last year have you failed to do what was normally expected of you because of your drinking?	☐ Never	☐ Less than monthly	☐ Monthly	☐ Weekly	☐ Daily or almost daily
Has a relative of friend or a doctor or other health worker been concerned about your drinking or suggested you cut down?	☐ No		☐ Yes, but not in the past year		☐ Yes during the last year

If the total score is five or above it might be useful to discuss alcohol consumption further.

If you would like further information or have any questions around alcohol use please ask to speak to a Doctor or Nurse. If you would like to calculate how many units of alcohol you have per week please go to http://units.nhs.uk

THE PEMBRIDGE VILLAS SURGERY
ONLINE ACCESS APPLICATION FORM

***All Patients**

Patient records are held on computer as well as paper. GP's are responsible for the confidentiality of these records. On occasions, we share information from the patient records with the local Health Authority, Hospitals and other NHS/Partner organisations in the interests of patient care.

I agree to my records being held under the above terms and I certify that the information I have provided is correct to the best of my knowledge.

Patient to complete:

Full Name	
Date of Birth	
Address	
Tel Number	
Email Address	
Practice Guidance read and understood:	Please choose

Surgery use only:

Proof of ID e.g. Passport, Driving Licence, membership card	Yes/No
Identity confirmed:	Yes/No

THE PEMBRIDGE VILLAS SURGERY

Sharing Your Medical Information

Your Choices

Ɩealth ǀĐŽƌŝĚĂƐɨȳals ĺ·ŒĖe ŭŊĺ·ǆed ŭƨ ʇŜŜǇ èƨǳŊ ŊŜŏƨŊŘs ăŜŏǳĖe ĺ·ȳŘ ŭƨ Ύĺ·ȳĺ·ƎŜ ŭĶŜΎ ŊŜăǇƨȳăǭōly ĺ·ȳŘ ǆȳ ŏƨȳŦǉŘŜȳŎŜ. There are ăŜǿeral Ύƨ Řels Ŧƨr ăĶĺ·Ŋǆƕ Řĺ·ta ǿĶǉŏĶ Ķĺ·ǿe ĺ·ff ōŜŜȳ Ǉǳt ǆȳŭƨ Ǉlace ȳĺ·ŭƨȳĺ·ffè ĺ·ȳŘ ŧƨŏĺ·ffè ǆȳ ŘǉŦŦŜŊŜȳŭ èears. ʈŜĺ·ăŜ ăŜŜ the 5ĺ·ŭa {Ķĺ·Ŋǆƕ ȼĺ·ōfe ǿĶǉŏĶ ăĶƨǿs what ǆȳŦƨŊΎĺ·ŭǉƨȳ is ăĶĺ·red ĺ·ȳŘ ŧǉȳks ōŜŧƨw Ŧƨr ΎƨŊŜ ǆȳŦƨŊΎĺ·ŭǉƨȳ.

Summary Care Records: ǿǿǿ.ȳĶăŏĺ·ŊŜŊŜŏƨŊŘă.ȳĶă.ǳʇ ĺ·ȳŘ Ķŭŭǉ://ǳƀăèăŭŜΎă.Ķăŏǉŏ.ƨƌǿ.ǳʇ

Care Data: ǿǿǿ.ȳĶă.ǳʇ/ĸŏĺ·ŊŜŘĺ·ŭĺ·

SystmOne Enhanced Sharing Data Model: ǿǿǿ.ǿŜăŭŧƨȳŘƨȳŏƌ.ȳĶă.ǳʇ/ǂǉĺ·ŭǉȳŭǉŊŜŏƨŊŘ

{Ķĺ·Ŋǆƕ yƨǳr reŏƨŊŘ benefits yƨǳ becausŜ:

- ¸ƨǳ ǿƨȳŭ neeŘ ŭƨ reǇŜĺ·t èƨǳr ΎŜŘǉcal hiăŭƨŊè
- ¸ƨǳ aǿƨǉŘ unȳŜŏŜăăĺ·Ŋè appƨǉȳŭΎents ĺ·ȳŘ tŜăŭă
- ¸ƨǳr health prƨŦŜăăǉƨȳal hĺ·s tĶe ŊƎĶt ǆȳŦƨŊΎĺ·ŭǉƨȳ at tĶe ŊƎĶt ŭǉΎŜ.

Patients have rights to dissent from sharing their data with other organisations.

Please tick your options **and sign** below to confirm:

Care Data:	**I do not consent** ☐	**I consent** ☐
SystmOne Enhanced Sharing Data Model:	**I do not consent** ☐	**I consent** ☐
Summary Care Record:	**I do not consent** ☐	**I consent** ☐
Summary Care Record Additional Info*:	**I do not consent** ☐	**I consent** ☐

***Summary Care Record Additional Information: If you wish to consent for additional information to be added to the SCR, coded items and the supporting free text will be added. This will include:**

- {ǉƎȳǉŦǉĺ·ȳt ΎŜŘǉŏĺ·ʄ histƨry (past and presŜȳŭ)
- ώŜĺ·ăƨȳ foŊ ΎŜŘǉŏĺ·ŭǉƨȳ
- !ȳŭǉŏǉǇĺ·ŭƨŊè cĺ·Ŗe ǆȳŦƨŊΎĺ·ŭǉƨȳ (ăǳŏĶ as infƨŊΎĺ·ŭǉƨȳ abƨǳt ŭĶe Ύĺ·ȳĺ·ƎŜΎent ƨf lƨȳƕ tŜŊΎ cƨȳŘǉŭǉƨȳă)
- 9ȳŘ of life cĺ·ŊŜ infƨŊΎĺ·ŭǉƨȳ (ŦŊƨΎ ŭĶŜ {//ǇƿǇл naŭǉƨȳal dĺ·ŭĺ·ăŜŭ)
- ǇΎΎǳȳǉăĺ·ŭǉƨȳă

The National Data Opt Out: Ƈƨr Ύƨ Ŗe ǆȳŦƨŊΎĺ·ŭǉƨȳ ƨr ŭƨ **"Opt Out"** ǇʈŜĺ·ăe Ŧƨŧŧƨw ŭĶis linʇ: **www.nhs.uk/your-nhs-data-matters/manage-your-choice/**

Full name: …………………………………………………………………………………..

Date of Birth: …………………………………………………………………………………..

Signature: ……………………………………………………………………………………

Date: ………………………….