

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)

<b>First Name</b>		<b>Surname</b>		
<b>Date of Birth</b>		<b>Sex</b>	Male	Female
<b>Address</b>				
<b>City + Postcode</b>				
<b>Telephone</b>		<b>Mobile Phone</b>		
<b>Occupation</b>		<b>Email</b>		
<b>Country of Birth</b>		<b>First Language</b>		

**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:

<input type="checkbox"/>	British or Mixed British	<input type="checkbox"/>	White + Asian	<input type="checkbox"/>	Other Asian Background
<input type="checkbox"/>	Irish	<input type="checkbox"/>	Other Mixed Background	<input type="checkbox"/>	Carribbean
<input type="checkbox"/>	Other White Background	<input type="checkbox"/>	Indian or British Indian	<input type="checkbox"/>	African
<input type="checkbox"/>	White + Black Carribbean	<input type="checkbox"/>	Pakistani or British Pakistant	<input type="checkbox"/>	Other Black Background
<input type="checkbox"/>	White + Black African	<input type="checkbox"/>	Bangladeshi or British Bangladeshi	<input type="checkbox"/>	Chinese

**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)

<input type="checkbox"/>	Wheelchair	<input type="checkbox"/>	Walking Aid	<input type="checkbox"/>	Hearing Aid
<input type="checkbox"/>	British Sign Language	<input type="checkbox"/>	Makaton Sign Language	<input type="checkbox"/>	Lip Reading
<input type="checkbox"/>	Large Print	<input type="checkbox"/>	Braille	<input type="checkbox"/>	Easy To Read
<input type="checkbox"/>	Other : Please state				

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

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

Other: .....

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

**\*Medical History**

Please state current:

<b>Height:</b>	<b>Weight:</b>	<b>Blood pressure:</b>
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Do you suffer or have suffered from any of the following conditions, if yes since when?

<b>Heart Disease</b>	Yes [ ] No [ ]	Since:
<b>Stroke</b>	Yes [ ] No [ ]	Since:
<b>Cancer</b> (Which type?)	Yes [ ] No [ ]	Since:
<b>Diabetes</b> (Which type?)	Yes [ ] No [ ]	Since:
<b>Asthma</b>	Yes [ ] No [ ]	Since:
<b>High blood pressure</b>	Yes [ ] No [ ]	Since:
<b>Epilepsy</b>	Yes [ ] No [ ]	Since:
<b>High Cholesterol</b>	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?	Yes	No	If yes, when?	
Are you using any contraception?	Yes	No	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.*

Alcohol Screening Questions	SCORE				
	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:

<b>Full Name</b>	
<b>Date of Birth</b>	
<b>Address</b>	
<b>Tel Number</b>	
<b>Email Address</b>	
<b>Practice Guidance read and understood:</b>	<b>Yes / No</b>

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**

Health professionals are trained to keep your records secure and to manage them responsibly and in confidence. There are several models for sharing data which have all been put into place nationally and locally in different years. Please see the Data Sharing Table which shows what information is shared and links below for more information.

**Summary Care Records:** <http://www.nhs.uk/scr> and <http://systems.hscic.gov.uk>

**Care Data:** <http://www.nhs.uk/caredata>

**SystemOne Enhanced Sharing Data Model** <http://www.westlondonccg.nhs.uk/your-health/your-patient-record>

Sharing your record benefits you because:

- You won't need to repeat your medical history
- You avoid unnecessary appointments and tests
- Your health professional has the right information at the right time

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

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

<b>Care Data:</b>	<b>I do not consent</b>	<b>I consent</b>
<b>SystemOne Enhanced Sharing Data Model:</b>	<b>I do not consent</b>	<b>I consent</b>
<b>Summary Care Record:</b>	<b>I do not consent</b>	<b>I consent</b>
<b>Summary Care Record Additional Info*:</b>	<b>I do not consent</b>	<b>I consent</b>

**\*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:**

- Significant Medical History (past and present)
- Reason for medication
- Anticipatory care information (such as information about the management of long term conditions)
- End of life care information (from the SCCI1580 national dataset)
- Immunisations

**The National Data Opt Out:** For more information or to “Opt Out” please follow this link: [www.nhs.uk/your-nhs-data-matters/manage-your-choice/](http://www.nhs.uk/your-nhs-data-matters/manage-your-choice/)

**Full name:** .....

**Date of Birth:** .....

**Signature:** .....

**Date:** .....