Kings Road & Eastcote Surgery

Kings Road Tel: 020 8422 1667

Eastcote Tel: 020 8866 1238

Patient Registration Questionnaire

Date of Completion ___/___/_____

Date and Time of New Patient health check: _____

Receptionist Signature: _____

Patient Details:

Title: _____ Surname: _____ Forename: _____

Full Address: _____

_____ Postcode: _____

Previous Address: _____

_____

Telephone Number -**Home:** _____ **Work:** _____

Mob: _____ **Email:** _____

D.O.B / / Martial Status: _____

Sex: **F** ☐ **M** ☐ Place of Birth (Country and City): _____

Do you have any children? **Y** ☐ **N** ☐

Please indicate the number of children you have _____

Next of Kin's: Title _____ Full Name: _____ Relationship: _____

Address of Next of Kin: _____

Telephone Number of Next of Kin: -**Home:** _____

Work: _____ **Mob:** _____

Do you give consent to share & access your medical records with your next of kin if yes please complete the name of you next of kin……..

Would you like to book appointment on-line **Y** ☐ **N** ☐

Would you like to order prescription: **Y** ☐ **N** ☐

Please state nominated pharmacy: _____

Are you a carer? **Y** ☐ **N** ☐ Does someone care for you? **Y** ☐ **N** ☐

Are you a foster carer? **Y** ☐ **N** ☐

Do you need an interpreter? **Y** ☐ **N** ☐

Ethnicity:

White British	( )	Chinese	( )	Other Asian	( )
White Irish	( )	Indian/British	( )	White & Black	( )
Caribbean	( )	Pakistani/British	( )	White & Asian	( )
African	( )	Bangladeshi/British	( )	Other Mixed	( )

Others (Please Specify) _____ Language Spoken: _____

Medical History:

Please read the following questions and tick **YES** or **NO**. If **YES**, then please give details.

Do you suffer from the following?	Yes	No	Details
Heart Attack, Angina			
Depression			
Epilepsy			
Diabetes			
Stroke			
Chronic Kidney Disease			
Asthma, Bronchitis or COPD			
Hypertension			
High Blood Pressure			
Cancer			
Tuberculosis			
Allergies			
Do you suffer from mental health condition?			
Any other serious Illness?			
Do you smoke or chew tobacco? If so, how many cigarettes a day?			
Do you drink alcohol? If so how much do you consume per week?			
Do you take any medications? **PLEASE PROVIDE THE LIST OF MEDICATION**			

***For Female Patients Only ***

	YES	NO	DETAILS
Do you have any children?			*If so how many?*
Have you had a hysterectomy?			
Which method of contraception do you use at present?			
When was your last smear test?			

Vaccinations:

Have you had any of the following vaccinations? Please gives the details of when they were given.

VACCINATION	YES	NO	DATE
Diphtheria			
German Measles			
Typhoid			
Cholera			
Yellow Fever			
Whooping Cough			
Polio			
Tetanus			
Measles			
BCG			
MMR			

FOR CHILDREN: PLEASE PROVIDE RED BOOK OR CHILDHOOD IMMUNISATION INFORMATION

Summary Care Record (SCR):

The SCR is intended to support patients care in urgent and emergency care settings. A patient's SCR will contain key health information including details of allergies, current medication and bad reactions to medicines to enable emergency services to avoid delay in treatment.

Opt in Opt Out (please circle appropriate)

Patient Signature_____ Date_____

Care Data

The information extracted for the care data programme will be used for the purpose of monitoring patient quality of care provided by local health services with a view to improvement to services.

Opt in / Opt Out (please circle appropriate)

Patient Signature_____ Date_____

OUT OF AREA REGISTRATION

I confirm and accept that if I live outside the catchment area I will **NOT** be obliged to a home visit by the GP.

Patient Signature_____ Date_____

TEXT MESSAGING CONSENT

I consent to the practice contacting me by text message for the purposes of health promotion and for appointment reminders.

I agree to advise the practice if my mobile number changes or if this is no longer in my possession.

Patient Signature_____ Date_____

TB Pilot Questionnaire

THIS QUESIONNARE ONLY TO BE FILLED IF YOU HAVE RECENTLY MOVED TO THIS COUNTRY OR HAVE LIVED HERE FOR LESS THAN 5 YEARS

1) Are aged between 16 – 35 years?

Yes ☐ No ☐

2) Which Country were you born or have last lived in? (for more than 6 MONTHS)

3) Have you lived in the UK less than 5 years?

Yes ☐ No ☐

4) Have you previously been diagnosed with Tuberculosis? Yes ☐ No ☐

If so what year?

5) Do you have any of the following symptoms?

- *Weight Loss ☐
- *Night sweats ☐
- * Fever ☐
- *Fatigue ☐
- * Loss of Appetite ☐
- *Persistent Cough ☐
- * Dark Green/Yellow Sputum ☐
- * Coughing up blood ☐
- * Chest Pain ☐

If Yes Please can you book an appointment with the Doctor

Thank you for completing the questionnaire