

# Welcome to Park End Surgery

Thank you for joining Park End Surgery. To ensure that we have your current medical and personal details, please complete this questionnaire. Please ask for assistance if you need it.

We are now registering patients from outside the area. If you are not within our practice area or even within Camden you can still register with us but we cannot provide out of hours services or home visits. You will need to call 111 to have these organised by a provider local to where you live.

**The information you give is confidential and is subject to the Data Protection Act**  
**If the patient is 18 or over they must complete this form themselves.**

**Surname:** ..... **First name(s):**.....  
**Title: (Mr/Mrs/Other)** ..... **Previous surnames :(if any)**.....  
**Male/Female:**..... **Date of Birth:**.....  
**Place of birth (including country and borough)** .....  
**NHS No** .....  
**EMIS number (to be filled out by reception)** ..... **Date**.....

## Address:

.....  
.....  
**Postcode**.....  
**Email**.....

## Telephone details

Only include details where you are happy to be contacted. Are you happy to receive text message reminders for appointments and other matters? Yes/No

**Home Telephone**.....  
**Mobile Telephone**.....  
**Work Telephone**.....

## Emergency contact

**Name**..... **Contact Number**.....  
What is your relationship to this person?.....

**Personal Details**

**What is your current occupation?**.....

**Do you have children?** Yes/No

If yes, please give name and date of birth:.....

**Are you registered disabled?** Yes/No If yes please give details .....

**Do you use a mobility aid?** Yes/No Stick Frame Wheelchair (circle)

**Are you housebound ?** Yes/No

**Carers**

...are people who are looking after a friend, relative, partner or neighbour who cannot manage on their own, maybe because they are elderly or ill, have a disability, have learning difficulties or a mental health problem, or are a child with special needs. If this applies to you, please ask reception for a carer's pack.

**(i) Are you a carer for someone?** Yes/No

If yes, are they registered at this practice? Yes/No

Name of the person you care for.....Their contact number.....

**(ii) Do you have a carer?** Yes/No

If yes, are they registered at this practice? Yes/No

Name of the person who cares for you..... Their contact number.....

**Allergies**

(Please list any allergies that you have to anything, including medications, giving details of reaction)

.....  
.....  
.....

**Past Medical History**

(Please list any illnesses, operations or other serious medical problems and the year of onset)

**Details**.....

.....  
.....  
.....  
.....

**Current medication**

(Please state when started, dose of medication and how often taken per day)

.....  
.....  
.....

*If you need repeat medication please make an appointment with a doctor for a review*

**Family History**

Is there a family history of: ?	Please circle	Their relationship to you(only mother/father/brother/sister)	Their age when first diagnosed
Heart attack / bypass surgery	Yes / No		
High blood pressure	Yes / No		
CVA/Stroke	Yes / No		
Diabetes	Yes / No		
Asthma/COPD	Yes /No		
Cancer (esp bowel, breast or ovary)	Yes / No		

If 'yes' please give details about the type of cancer

Other family history? eg muscular dystrophy, haemophilia, sickle cell, polycystic kidneys, other illnesses? Yes/No Please give details

**Ethnicity**

This information will help us to ensure that our service is reaching everyone in our community

	Tick	Office use		Tick	Office use
British or mixed British		9i0	Pakistani/British		9i8
Irish		9i1	Bangladeshi/British		9i9
Other White.....		9i2	Other Asian.....		9iA
White and black Caribbean		9i3	Caribbean		9iB
White and black African		9i4	African		9iC
White and Asian		9i5	Other black.....		9iD
Other mixed.....		9i6	Chinese		9iE
Indian/British Indian		9i7	Other Specify.....		9iF

**Main language spoken** .....

Interpreter needed? Yes / No If yes, specify language .....

**Women only**

**Last smear**

Date: .....Place: .....Result:.....Comments:.....

**Last mammogram**

Date:.....Place: .....Result:.....Comments:.....

Have you ever had an abnormal smear? Yes / No

If yes please give details (date, place, treatment).....

Have you had a hysterectomy? Yes / No

If Yes please give details (date, place, reason) .....

What contraception are you using at present .....

Have you ever had a blood test to check if you are immune to rubella (german measles)?

Yes/No Date.....Result.....

**Smoking:**

**Do you smoke?** Yes / No (circle)

**If 'No' have you ever smoked** Yes / No (circle)

**If 'Yes' how many per day :** cigarettes..... / cigars..... / pipe.....

**If you are an ex-smoker, what year did you give up?**.....

**Please ask reception if you would like a booklet to help you to stop smoking**

**Alcohol Use:** How many units of alcohol do you consume each week? \* Total .....

(Please tick your answers in Qs 1,2 & 3 below; total the 3 scores; enter total in box below)

**1. How often do you have a drink containing alcohol? \***

- Never (Score 0)
- Monthly (Score 1)
- 2-4 times a month (Score 2)
- 2-3 times a week (Score 3)
- 4 or more times a week (Score 4)

**2. How many standard drinks\* containing alcohol do you have on a typical day when you are drinking?**

- 1-2 (Score 0)
- 3 or 4 (Score 1)
- 5 or 6 (Score 2)
- 7 to 9 (Score 3)
- 10 or more (Score 4)

**3. How often do you have 6 or more standard drinks\* on one occasion?**

- Never (Score 0)
- Less than monthly (Score 1)
- Monthly (Score 2)
- Weekly (Score 3)
- Daily or almost daily (Score 4)

\*A standard drink of alcohol (around 10mls or 8g) is contained in:

- A small glass of standard strength wine -12% (125ml)
- A single pub measure of spirits (25ml) or half a pint of normal strength beer or lager

**Total score for Questions 1,2&3 .....**

Women: score higher than 4 or Men: score higher than 5?

Please ask for a Sensible Drinking Pack

**Exercise:** How many sessions \* do you do each week? (tick below)

0       1       2       3       3+

\* 1 session = 20 minutes of aerobic activity sufficient to raise your pulse and make you breathless

## One Stop New Patient Checks – over 16's only

Using the equipment in reception please to complete the following steps and hand in your form, and urine sample, to reception. Please ask if you need assistance or advice.

**Height**..... **cm**                      or                      **Ft**                      **inches**

To measure your height please use the measuring slide on the right hand side of the reception desk. Position yourself under the measuring slide with your back and head straight. Push the measuring slide onto the top of your head and read of the height.

**Weight**..... **KG**                      or                      **Stone**                      **lbs**

Please use scales provided if required. Switch on by pushing the switch on the front edge with your foot

### Blood Pressure

1. Sit on the chair in front of the monitor
2. Ensure your skin is exposed above your elbow before inserting your arm into the insert section
3. Insert arm as far as you can up to your armpit and relax with your palm facing upwards
4. Press the green start button
5. The cuff will inflate around your upper arm and the measurement takes a minute or so
6. When complete the cuff will automatically deflate
7. Record your reading

**Systolic**.....mmHg

**Diastolic**.....mmHg

### Urine

Please ask for a urine bottle from reception

**Label it with your name, DOB and Date and write NEW PATIENT CHECK on the bottle.**

Hand it to reception staff who will test it for sugar and protein at the end of surgery; they will ring you if there is a problem

### First appointments

If you suffer from any chronic condition requiring regular medication or review, urgently need repeat medicines or have an immediate medical problem please book either a 10 minute same day appointment or a routine 15 minute appointment depending on the urgency

### Online services

Please ask reception for details on how to book and cancel appointments, order repeat prescriptions, view your medical records or send messages to your GP.

### Over 16's HIV Test

Are you over 16 and would like an HIV test

Yes / No (circle)

#### For office use only

**Heath Care Assistant please check urine to see if follow up appointment is needed**

Urine glucose result.....Urine protein result ..... Normal no action [ ]

abnormal contact patient [ ]

Carer's pack given [ ] Lifestyle advice leaflet given [ ] Smoking Information offered [ ]

Alcohol pack given [ ]

Appointment needed for chronic disease management or for routine medicines [ ]

Appointment made [ ]

The above has been coded onto EMIS [ ] Initials..... Date.....

## Receive e-mail reminders when you are due for a check-up!

We will only e-mail patients over 18 or their parents.

We will use email to communicate with you only about non-sensitive and non-urgent issues such as: Recall screening for patients with long-term conditions, appointment scheduling, general non-urgent correspondence and test results

All emails to you will be made a part of your medical record. You will have the same right of access to such emails as you do to the remainder of your medical file.

Email communication is not intended to be used as a form of two-way communication – it is solely for the purpose of sending you electronic correspondence.



**Consent given to receive test results by email and SMS**

**Yes/No**

## DATA SHARING

Please read and make your selection by ticking the box or boxes next to the right statement. Then please fill out the required information below, sign and date the form and return it to reception.

### Recording Consent of New Patients for Data Sharing Initiatives in Camden

<p><b>Camden Integrated Digital Record</b> Local Initiative</p> 	<p>Camden Integrated Digital Record (CIDR), enables your Camden care providers, when they are treating you, to view the relevant information about the care you receive, and so give you the best possible care. <b>PLEASE READ ATTACHED INFO</b></p>	<p>I want to:</p> <p>Opt in to CIDR. <input type="checkbox"/></p> <p>Opt out of CIDR. <input type="checkbox"/></p> <p><b>IF YOU OPT OUT YOU MUST COMPLETE THE OPT OUT FORM ATTACHED.</b></p> <p><b>ADMIN- do not code opt put.</b></p>
<p><b>Summary Care Record</b> National Initiative</p> 	<p>If you have a Summary Care Record your health care providers can view your medication, bad reactions to medications and allergy information when treating you in an emergency or when your practice is closed.</p>	<p>I want to have a Summary Care Record. <input type="checkbox"/></p> <p>I do <b>not</b> want to have a Summary Care Record. <input type="checkbox"/></p>

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Park End Surgery

## Application for online access to my medical record

### Adults only (18+)

**Please complete using block letters**

Surname	Date of birth
First name	
Address	
Postcode	
Email address	
Telephone number	Mobile number

**I wish to have access to the following online services (please tick all that apply):**

1. Booking appointments	<input type="checkbox"/>
2. Requesting repeat prescriptions	<input type="checkbox"/>
3. Accessing my medical record	<input type="checkbox"/>

**I wish to access my medical record online and understand and agree with each statement (tick)**

1. I have read and understood the information leaflet provided by the practice	<input type="checkbox"/>
2. I will be responsible for the security of the information that I see or download	<input type="checkbox"/>
3. If I choose to share my information with anyone else, this is at my own risk	<input type="checkbox"/>
4. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible	<input type="checkbox"/>
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	<input type="checkbox"/>
6. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible.	<input type="checkbox"/>

Signature	Date
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Please note if you have not registered your log-in details online within 3 weeks of issue, they will be invalid and need re-issuing.

**For practice use only**

Patient NHS number		Practice computer ID number	
Identity verified by (initials)	Date	Method Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/> Photo ID and proof of residence <input type="checkbox"/>	
Authorised by		Date	
Date account created			
Date passphrase sent			
Level of record access enabled All <input type="checkbox"/> Prospective <input type="checkbox"/> Retrospective <input type="checkbox"/> Detailed coded record <input type="checkbox"/> Limited parts <input type="checkbox"/>		Notes / explanation	