WELCOME TO
ISLINGTON CENTRAL MEDICAL CENTRE

Thank you for joining Islington Central Medical Centre.
To ensure that we have up to date medical and personal details please complete this registration questionnaire. The information you give is CONFIDENTIAL. PLEASE PRINT CLEARLY. If you have problems completing any section please ask for assistance.

PERSONAL INFORMATION

Title (Mr/Mrs/Miss/Ms/Other)	**Male/Female**
Surname	**Forename**
Previous Names (if any)	
Date of Birth	**Marital Status**
If you were born in London: Which Borough or Hospital? _____	
If you were born in Scotland please provide your NHS Number from your Health authority/previous GP in Scotland: _____	
If Child: Parents name:	**Parents date of birth:**
Address	
Home Telephone Number	**Mobile Number** **Do you consent to receiving TEXT MESSAGES?** ☐ **Work Number**
Email Address	
Occupation	
First language	
Interpreter required (*circle which applies to you*)	**YES / NO**
Person to be contacted in case of an emergency – NEXT OF KIN **Title/ First Name/ Surname:** **Contact Number:** **Relation to you:**	

CHILDREN'S VACCINATIONS

Children **under 6 years old** being registered must provide us with the **baby red book** or a record of their immunisations if they have entered from outside the UK and **MUST book an appointment with the nurse**.
*The child will **not** be registered on to our system until they have been seen by the nurse*

NHS HEALTH CHECK

If you are **between 35 and 74** with **no pre-existing medical conditions** we would like to invite you for a **free NHS health check** which can help to prevent heart disease, stroke, diabetes and kidney disease. Please ask reception for more details as you will need to book an appointment with the practice nurse **(2-3 weeks advanced).** You will be provided blood test form first before the initial appointment with the nurse.
FREE Hepatitis B or C Blood test – appointments with the Nurse

For office Use Only			
Two items of proof of residency	YES / NO	**Form checked and fully completed**	YES / NO
NHS Health check invite	☐	**Date of appt for NHS health check -**	
NHS Health check decline	☐		
Receptionist's Initials:……		**Date……**	

MEDICAL DETAILS

Medical History (past and present) e.g. diseases, operations with dates if known
Do you suffer from any of the following? Please put date of onset.

CURRENT TREATMENTS/ILLNESSES	YES	NO	YEAR ILLNESS STARTED
Heart disease (Angina or Heart Attack)			
Heart failure			
Stroke			
Hypertension (If yes please complete the hypertensive questionnaire)			
Diabetes			
COPD			
Epilepsy			
Hypothyroidism			
Asthma			
Learning disabilities			
Osteoporosis			
Rheumatoid arthritis			
CURRENT TREATMENTS/ILLNESSES	**YES**	**NO**	**YEAR ILLNESS STARTED**
Any other medical illness: e.g. Depression, Dementia			

CURRENT MEDICATION (If you have a spare repeat prescription please include a copy)
DRUG ALLERGIES

FAMILY HISTORY	YES / NO	Relation to you
Stroke		
Heart disease under 60		
Heart disease over 60		
Diabetes under 60		
Asthma		
Cancer		

LIFESTYLE

Blood Pressure	**(THIS WILL BE CHECKED BY STAFF)**
Height	**Weight**
Do you smoke? YES / NO	**Cigarettes per day:** **Tobacco per day:**
Never smoked (please tick the box)	☐
Ex-smoker	**Cigarettes per day:** **Tobacco per day:**
Would you like help giving up smoking? (*circle which applies to you*)	**YES / NO**

WOMEN ONLY

Have you had a cervical smear? YES / NO	**Date of last cervical smear:** **Result:**
Current Contraception	
Have you had a mammogram? YES / NO	**Year:** **Result:**
Have you had a hysterectomy? YES / NO	**If Yes which Year:**

CARERS

I have a carer YES / NO	**I am a carer YES / NO**
Name of carer: **Telephone number of carer:**	

PATIENT PROFILING

The practice in line with other healthcare providers and all other statutory services is now collecting information about our patients' ethnicity. This information will help us learn more about the health needs of our local community and allow us to plan services. All the information we receive will be used and treated with strictest confidence.

If you have any queries about completing this form please ask a member of staff. Otherwise please complete this form below by ticking the ethic group to which feel you belong.
Thank you.

WHITE

British ☐
Irish ☐
Gypsy or Irish Traveller ☐
Other White ☐

BLACK/ BLACK BRITISH

Caribbean ☐
African ☐
Other Black ☐

MIXED/MULTIPLE ETHNIC GROUPS

White & Black Caribbean ☐
White & Black African ☐
White & Asian ☐
Other Mixed ☐

ASIAN / ASIAN BRITISH

Chinese ☐
Indian ☐
Pakistani ☐
Bangladeshi ☐
Other Asian ☐

OTHER

Arab ☐
Any other Ethnic Group ☐

ALCOHOL SCREENING TOOL

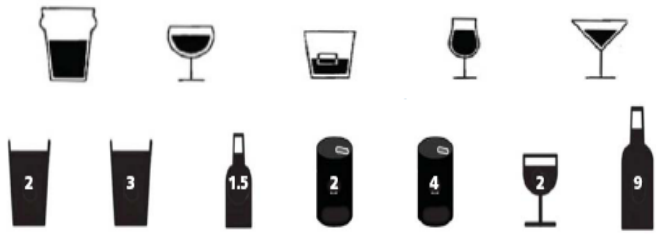
1 unit is typically:

Half-pint of regular beer, lager or cider; 1 small glass of low ABV wine (9%); 1 single measure of spirits (25ml)

The following drinks have more than one unit:

A pint of regular beer, lager or cider, a pint of strong /premium beer, lager or cider, 440ml regular can cider/lager, 440ml "super" lager, 250ml glass of wine (12%)

UNIT GUIDE



The following questions are validated as screening tools for alcohol use

AUDIT- C Questions	**Scoring system**					**Your score**
	0	**1**	**2**	**3**	**4**	
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3-4	5-6	7-9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					TOTAL :	

A score of **less than 5** indicates *lower risk drinking* (see overleaf)

Scores of 5+ requires the following 7 questions to be completed:

AUDIT Questions (after completing 3 AUDIT-C questions above)	**Scoring system**					**Your score**
	0	**1**	**2**	**3**	**4**	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
						TOTAL

Scored 16 or above? Would you like a telephone consultation with the Practice Nurse?

Yes ☐ **No** ☐

New patient name/Date of birth : _____