# **Sobell Medical Centre – Dr V K Gupta**

272 Holloway Road, London, N7 6NE Tel: 0207 609 3050

[www.sobellmedicalcentre.nhs.uk](http://www.sobellmedicalcentre.nhs.uk)

# **NEW PATIENT HEALTH CHECK**  DATE: / /

# PLEASE ANSWER AS MANY QUESTIONS AS POSSIBLE.

IF NOT SURE LEAVE BLANK AND DISCUSS WITH DOCTOR/NURSE.

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SURNAME: Mr/Miss/Mrs/Ms \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: ……………………. DOB: / / NHS (National Health Number) ……………….. ………………………………….. Phone: Home ………………………….. Mobile ……………………………………………

………………………………….. Email………………………………………..

………………………………….. ***Do you give permission to be contacted via text messages and emails? Yes / No***
………………………………….. **What is your preferred method of contact**: ……………………………………………………

**Next of Kin**: Name……………………… Contact No: …………………………………. Relationship to you: ……..................................

**LANGUAGE** – Do You Speak English? YES / NO If **NO** what is your Main Spoken Language …………………………………….

**Do you look after someone?** ………………………………… **Does someone look after you?** ………………………………

**ETHNICITY** ……….…………………… **OCCUPATION/JOB** …………………………………………………

**Do you suffer from any of the following?**

ALLERGIES NO YES Date since ……………………………………………..

HAYFEVER NO YES Date since ……………………………………………..

ASTHMA NO YES Date since ……………………………………………..

DIABETES NO YES Date since ……………………………………………..

HEART PROBLEMS (e.g. ANGINA) NO YES Date since ……………………………………………..

HIGH BLOOD PRESSURE NO YES Date since ……………………………………………..

**OPERATION or ILLNESS** NO YES ………………………………………………………….

**Any Other Relevant** Information) ………………………………………………….………………………………………..

………………………………………………………………………………………………………………………………………

**Do you?**

SMOKE YES NO How many a day? …………………..

EX-SMOKER YES NO Date stopped? ………………………

DRINK ALCOHOL YES NO Units per week? …………………….

EXERCISE YES NO Light / Moderate

**Your Diet**: Normal / Vegetarian / Low-fat / Low-sugar / Diabetic / other ……………..

Do you take any MEDICATION? Yes / No **if Yes, Please list medication**

……………………………………………………………………………………………….………………………

WEIGHT: ……………. HEIGHT: …………………..

**VACCINATIONS –** If you have any evidence of having vaccinations please bring it with you when you attend the New Patient Health Check.

 Tetanus Polio Rubella Hepatitis

Dates: ……….…. ……….. ……………. …………….

**CHILDHOOD VACCINATIONS – Please bring your child/children immunisation book record when you attend the New Patient Health Check**

**FAMILY HISTORY**: Diabetes Y/N Heart Disease Y/N High Blood Pressure Y/N Asthma Y/N CVA/Stroke Y/N Cancer Y/N

If **YES** family member……………. …………………… ……………………… ………… ……………. ……………

## ---------------------------------------------------------------------------------------------------------------------------------------

## WOMEN ONLY

Cervical Smear: YES/NO Date of Last Smear:………………… Result:………………. Where ……………….

CONTRACEPTION TYPE USED? ……………………………

PREGNANCIES: YES/NO CHILDREN: YES/NO If Yes Age ……………………..

ABORTION: YES/NO If YES Date ……………

MISCARRIAGE: YES/NO If YES Date ……………

For Office use only:

Accountable GP Read code: 9NN60 & 67DJ

Consent Read codes for SMS: 9NdP, Emails: 8B3E
Declined Read code for SMS: 9NdQ, Emails: 9Ndy



AUDIT – C

|  |  |  |
| --- | --- | --- |
| **Questions** | **Scoring system** | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink containing alcohol? | Never | Monthlyor 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 Score :**

**Scoring:**

A total of 5+ indicates increasing or higher risk drinking. Please fill in below if scored 5 or more on the Audit C

|  |  |  |
| --- | --- | --- |
| **Questions** | **Scoring System** | **Your Score** |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink containing alcohol? | Never | Monthlyor 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 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 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 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 the night before because you have 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 you cut down? | No |  | Yes, but not in the last year |  | Yes, during the last year |  |

 **Total Score :**

 **Scoring: 0-7 lower risk, 8-15 increasing risk, 20+ possible dependence**

Sobell Medical Centre

272 Holloway Road – London N7 6NE

**GDPR Patient Consent Form**

By completing this form you (the patient) consent to being contacted by Sobell Medical Centre by the methods you choose below.

A copy will be securely stored by the practice to record your consent being given. If you wish to withdraw this consent at any point, please contact the practice in writing.

|  |  |
| --- | --- |
| **Method of communication** | **Consent to receive communication via:** |
| SMS (text message) | Yes / No |
| Telephone | Yes / No |
| Email | Yes / No |
| Post | Yes / No |
| Record Sharing/Shared Data with other NHS organisations, so in an emergency a NHS hospital for example can view your stored records. | Yes / No |

|  |  |
| --- | --- |
| **Your Full Name** |  |
| **Date of Birth** |  |
| **Full Address, including postcode** |  |
| **Home Telephone Number** |  |
| **Mobile Telephone Number:** |  |
| **Email address:** |  |

**Privacy Protection**

Our practice has a strict confidentiality policy. For more information please visit our website or ask a member of staff.

This information is not shared with any third party organisations.

(Patients preferences updated on clinical system Yes /No)



**Your emergency care summary**

**My Summary Care Record Choice**

A. Please complete in BLOCK CAPITALS

Title..................................................................Surname / Family name....................................................

Forename(s)................................................................................................................................................

Address.......................................................................................................................................................

Postcode .......................................... Phone No.............................................. Date of birth.......................

NHS Number (if known)..............................................................................................................................

B. If you are filling out this form on behalf of another person or a child, their GP practice will consider this request. Please ensure you fill out their details in section A and your details in section B

Your name........................................................................... Your signature..............................................

|  |  |
| --- | --- |
| **Summary Care Record Options** | **Please****Tick** |
| **YES** I would like a Summary Care Record containing details of my medications, allergies and any bad reactions to medications I have had |  |
| **YES** I would like a Summary Care Record containing details of my medications, allergies and any bad reactions to medications I have had AND any other information that I have agreed with my GP Practice to have included in my Summary Care RecordsPlease indicate what information you would like adding if you know |  |
| **NO** I do not want a Summary Care Record |  |

Relationship to patient ............................................................................... Date ......................................

**If you do not return this form, a Summary Care Record will be created for you based on implied consent.**

**What does it mean if I DO NOT have a Summary Care Record?**

|  |  |  |
| --- | --- | --- |
| NHS healthcare staff caring formay not be aware of your current medications, allergies you suffer from and any bad reactions to medicines youhave had, in order to treat you safely in an emergency. | Your records will stay as they are now, with information being shared by letter, email, fax or phone. | If you have any questions, or if you want to discuss your choices, please:• contact your local Patient Advice Liaison Service (PALS); or• contact your GP practice. |