Green Street Green Medical Centre New Patient Questionnaire

Welcome to Green Street Green Medical Centre. As it may take some time to obtain your medical records from your previous doctor, we would be grateful if you would complete a questionnaire for yourself and each family member registering with this practice.
The information is strictly confidential.

PLEASE USE BLACK INK

Surname		**Title**	
First Name		**Middle Names**	
Address			
Date of Birth		**Place of Birth**	
Telephone Number/s	This is vital so that we can contact you if necessary	**Daytime**	
		Home	
		Mobile	
Email Address			
Occupation / School Attends		If under 16: *(please circle)*	
		Adopted: Yes / No	Fostered: Yes / No
Ethnicity: ***(please circle)***	**1. White** **4. Black – other** **7. Bangladeshi** **9. Other Ethnic – non mixed** **2. Black Caribbean** **5. Indian** **8. Chinese** **10. Other Ethnic – mixed origin** **3. Black African** **6. Pakistani** **11. Prefer not to say** **Main Language Spoken:**		
Are you a carer for anybody?	Yes / No *(please circle)* If yes, who?		
	Would you like to be added to our Carers Register? Yes / No *(please circle)*		
	Are you a young carer? *(i.e. someone who looks after a parent?)* Yes / No *(please circle)*		
Housebound	Do you consider yourself to be housebound? Yes / No *(please circle)*		

Next of Kin (emergency contact)

Mr ☐	**Mrs ☐**	**Ms ☐**	**Miss ☐**	**Other**
Name:				
Tel:				
Home Address:				
Post Code:				
NOK relationship to you:				

Patient Communication Preferences

The surgery may need to contact you with regards to appointments, health services, screening etc. Please let us know how you would like us to keep in touch with you.				
Any Method ☐	Mobile ☐	Email ☐	Text ☐	Letter ☐

Summary Care Records

The Practice is Summary Care Record live, which means that your prescriptions, allergies and adverse reactions are saved on a central database for use by A & E and other Care professionals, if you require treatment when the surgery is closed. Please select your preference from the options below.
☐ Express consent for medication, allergies and adverse reactions only
☐ Express consent for medication, allergies and adverse reactions AND additional information
☐ Express dissent (**opted out**) – Patient does **NOT** want summary care record (Please ask Reception for an Opt-Out form

Online Access

You can view parts of your medical records, order repeat prescriptions and make routine appointments. Please not you will need to show photo id to finalise this request Would you like this activated? Yes ☐ No ☐ (If yes, please read below and sign:
I will be responsible for the security of the information that I see or download
If I choose to share my information with anyone else, this is at my own risk

Signature		**Date**	

Past medical History

Please list any Major Illnesses / Accidents or Operations. Please continue onto the next page, if necessary

Date	Major Illnesses / Accidents or Operations	Date	Major Illnesses / Accidents or Operations

Do you have a close family history of heart disease or stroke?		Yes / No *(please circle)*
If yes, please give details: (This means mother or father, sister or brother who either suffers from or who has died from heart disease or stroke of any sort)		
Any Family History of Diabetes Mellitus?	Yes / No *(please circle)*	**If yes, who?**

Please list any medication that you are taking:

Medicine	Dosage or Frequency	Reason

Please list any drug allergies:

HIV Tests

All adult patients in London are now being offered a free HIV test when they register with a new GP. The Department of Health recommends this as 100,000 people in the UK are now living with HIV, half of them live in London and 1 in 5 do not know they have it. Free effective treatment is available now to all on the NHS regardless of immigration status. If you would like to have an HIV blood test done please ask your doctor or nurse at your next consultation or speak to our Reception Manager.

FEMALES ONLY

Are you using contraception?	Yes / No *(please circle)*
If yes, which type (please name if using a pill)?	
When and where did you last have a cervical smear?	