Your Allocated Named GP is: **Dr C Elliott**

Local Resident/Staff Health Registration Form

Practice Leaflet given to Pt with Named GP? ☐

All information is strictly confidential

*(Please complete form in **BLUE INK** if possible & **BLOCK CAPITAL LETTERS**)*

1. **Gender**: Male ☐ Female ☐
2. **Family Name/Surname:**
3. **Date of Birth**: ____/_______/______ (Day Month Year) **4.** Title (Mr/Miss/Mrs/Ms): ________________
5. **Given Name/Forename**: **6.** Middle Name (s):
7. Known As/Calling Name:
8. Previous Family Name/Previous Surname:
9. NHS Number: ☐☐☐☐☐☐☐☐☐☐ (10 digits long) **10.** Marital Status: ________________

11. Ethnicity

British/Mixed British ☐ Indian/British ☐ White & Black Caribbean ☐ Other Mixed ☐ African ☐ Other White ☐
Pakistani/British ☐ White & Black African ☐ Chinese ☐ Irish ☐ White & Asian ☐ Bangladeshi/British ☐
Caribbean ☐ Other Black ☐ Other Asian ☐ Other ☐ If Other please specify ____________________

12. Main Spoken Language: ________________ **13.** Will you require an Interpreter? Yes ☐ No ☐

Current Address in London

14. House Name/Flat Number: ____________________
Number & Street: ____________________
Town: ________________ County: ________________ Postcode: ____________

Contact Details

15. Home Telephone Number: **16.** Work Telephone Number:
17. Mobile Telephone Number:
18. Email Address: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
(Please provide us with the e-mail address you use most frequently)

Previous Home Address in the UK

19. House Name/Flat Number: ____________________
Number & Street: ____________________
Town: ________________ County: ________________ Postcode: ____________

Patient Access – You must complete a separate registration form –Please ask at Reception

20. This is an on-line service that allows you to book appointments, order repeat prescriptions, view your medical records and also update your details, if you would like to register for this please ask Reception for an application.
21. Would you like to opt out of SMS messages? Yes ☐ No ☐
(NB: We send Appointment reminders via SMS for all booked appointments)
22. We may introduce Video Consultations in the future, if you are interested in this service please provide your video conferencing details here: e.g. Skype name etc. ____________________

Next of Kin Details

23. Next of Kin's Relationship to you: ____________________
Title: ____Family Name:____________ Given Name: ____________ Telephone: ____________
24. If required in an emergency situation do you give Gower Place Practice the permission to discuss your medical records with the above person? Yes ☐ No ☐

Place of Birth Details

25. Country of Birth: ____________________**25.** Place of Birth:____________________

Previous GP Details in UK

26. Previous GP's Name/Surgery Name: ____________________
Previous GP's Address: ____________________

Arrived from Overseas (Questions 27-28)

27. Date you arrived in the UK for the first time : _____/_______/______ (Day Month Year)
28. Did you register with a GP the first time you came to the UK? Yes ☐ No ☐

Lifestyle

34. Your current Smoking status is: **a)** Never Smoked ☐ **b)** Ex-Smoker ☐ ____ per day. Age you started smoking ____
c) Cigarette Smoker _____ per day **c1)** Age you started smoking_______ **d)** Other ☐ please state ____________

35. Height: _______cm | **36.** Weight: _____Kg | **37.** How many units of alcohol do you drink per week? ____

1 Unit = ½ pint of beer/1 medium glass of wine/ 1 spirit measure e.g. vodka/Rum/Gin

Alcohol Consumption Questionnaire

Questions	Scoring System					Your score
	0	1	2	3	4	
1. 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	=
2. 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+	=
3. 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	=
If you scored 5 or more please answer Questions 4 to 10.					**Total**	=
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	=
5. 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	=
6. 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	=
7. 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	=
8. 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	=
9. 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	=
10. Has a relative or friend, doctor or 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	=

38. Are you A Carer or do you have a Carer? I am A Carer I Have a Carer Not applicable

39. Details of Carer/Person you Care for: Relationship: ________________________________
Title: ______Family Name:____________________ Given Name: ________________ Telephone: __________________________

Gynaecological Examination to detect pre-cancer cells/Smear Test/Pap Smear/ 子宫颈抹片检查,可以早期侦测子宫颈癌

40. Date of last Cervical Smear? (PAP Test) _______/_________/_________

41. Where was it taken? **GP Surgery** ☐ (GMS another practice) **Other UK Clinic/Hospital** ☐ (Not GMS) **Abroad** ☐(Not GMS)

42. Cervical Smear Result: Negative/Normal ☐ Abnormal ☐ Details ______________________________________

Please read the following important information

We recommend HIV testing for all new patients if you do not wish to have this please inform the Doctor or Nurse at your consultation

Personal Medical History (Please tick if you have had/have any of the following and give more details where possible)

Heart Attack		Heart Disease		Heart Failure		Angina	
Stroke/TIAs		Hypertension (requiring medication)		Hypothyroidism (Underactive thyroid gland)		Depression (requiring medication)	
Learning Disabilities		Diabetes Type 1		Diabetes Type 2		Epilepsy	
COPD		Asthma Requiring Inhalers		Chronic Kidney Disease		Schizophrenia	
Bipolar Disorder		Other Psychoses		Cancer		Dementia	

43. Please give details of current or past medical problems other than previously specified:

44. Please give details of any hospital treatment or operations?

45. Please state any relevant medical **Family History**: Mother: ___________________ Father: ________________________
Brother: _____________________Sister: __________________ Other (State relationship): ______________________

46. Please give details of **any medication** you take on a regular basis:

47. Allergies: Please give details of any allergies you have:

Summary Care Record (SCR) For more information go to www.nhscarerecords.nhs.uk/summary or take a leaflet from reception

48. Would you like a Summary Care Record? Yes ☐ No ☐ Please see information provided.

Care.data For more information go to www.nhs.uk/nhsengland/thenhs/records/healthrecords/pages/care-data.aspx or take a leaflet from reception.

49. Are you happy for your anonymised data to be shared for secondary use? Yes ☐ No ☐

50. Are you happy for your anonymized data to be shared with 3rd parties by HSCIC? Yes ☐ No ☐

CIDR Camden Integrated Digital Record, is a local initiative for Camden residents, to enable your care providers in Camden to view the relevant information when treating you and so give you the best possible care.

51. You are **automatically Opted in** to CIDR. If you would like to **Opt Out** please ask Reception for the CIDR Opt out form.

52. Your Signature:___________________________________ Date: ______/______/_______