Abbotswood Medical Centre
12 Katherine Place, Abbots Langley, WD5 0BT

Today's Date:

Registration at Abbotswood Medical Centre, 12 Katherine Place

Dear Patient,

We are happy to register you and welcome you to the surgery. Please take note of the following so that this process can take place without delay.

- We shall need a copy of a utility bill to check your address, to ensure you live in our catchment area. We will also need to see your passport or photographic ID
- We will require the name and address of your previous GP in this country and your NHS number
- It is very important if you were born outside this country or have ever lived abroad that you provide us with your date of arrival in, or return to the UK and the address you first lived at
- Please complete our registration forms as comprehensively as possible in order for us to gain some background to your present health
- It takes 7 working days for all of your documentation to be processed and computerised, after which we are able to offer you an appointment
- In order to register children, we need to see their red health book (or equivalent) to verify their immunisations and vaccinations (new born babies are exempt from this requirement)

Please sign the declaration form below to confirm acceptance of our procedures.

If you have any questions, please ask the Reception Staff who will be willing to help in any way they can.
We recommend you read a copy of our practice leaflet for more information about our services.

As a long established and experienced practice, we are delighted to welcome you to our list.

For more information about the services we offer, please refer to your new patient pack or see our website: www.abbotswoodmedicalcentre.co.uk

PATIENT DECLARATION

I have read the above and understand how to access the services at the Practice.
I agree to follow the guidelines and behave appropriately.
I am aware that rudeness and aggressive behaviour will not be tolerated and will result in removal from the practice list.

Signature

Date

ABBOTSWOOD MEDICAL CENTRE
NEW PATIENT QUESTIONNAIRE

TITLE:
Forename: Middle names: Surname:
DOB:_____

NHS number:_____

MARITAL STATUS (Please circle): Single Married Cohabiting Divorced Widow
ETHNICITY:
CONTACT TELEPHONE NUMBERS: HOME: MOBILE:

ADDRESS including Postcode:_____

_____

EMAIL ADDRESS:

OCCUPATION:

Previous GP Name & Address: _____

_____ ____

SMOKING STATUS:
☐ SMOKER – CIGARETTES PER DAY _____

☐ EX SMOKER – DATE/YEAR QUIT _____ DATE STARTED_____
NUMBER SMOKED/DAY in the past _____
☐ NON-SMOKER

ALLERGY STATUS:
☐ NO KNOWN ALLERGIES
☐ DRUG/MEDICATION ALLERGY (please state)_____
☐ ANIMAL/PET ALLERGY (please state)_____
☐ POLLEN/TREE/PLANT ALLERGY (please state)_____
☐ OTHER (please state)_____

HEIGHT: (cm) WEIGHT: (kg)

If you are between the ages of 15 & 24 and are sexually active, have you done a chlamydia test in the last year? YES/NO

WOMEN ONLY
METHOD OF CONTRACEPTION _____

DATE OF LAST CERVICAL SMEAR _____

Pregnancy history:
Miscarriages:
Terminations:
No. of pregnancies to term and any complications:

If you do not have regular cervical smears, please state why_____

Have you had a hysterectomy? (If yes, please state the reason) _____

Do you use HRT? YES/NO

YOUR OWN PAST AND CURRENT MEDICAL HISTORY AND YEAR/AGE OF ONSET

		YEAR/AGE OF ONSET
☐	ASTHMA	_____
☐	ATRIAL FIBRILLATION	_____
☐	CANCER (including type)	_____
☐	CHRONIC KIDNEY DISEASE	_____
☐	CORONARY HEART DISEASE	_____
☐	DEMENTIA	_____
☐	DEPRESSION	_____
☐	DIABETES (please indicate if TYPE 1 or 2)	_____
☐	EPILEPSY	_____
☐	HEART FAILURE	_____
☐	HYPERTENSION/HIGH BLOOD PRESSURE	_____
☐	HYPOTHYROIDISM	_____
☐	LEARNING DISABILITIES	_____
☐	MAJOR OPERATIONS	_____
		_____
		_____
☐	MENTAL HEALTH	_____
☐	OSTEOPOROSIS	_____
☐	STROKE/TIA	_____
☐	OTHER	_____

FAMILY MEDICAL HISTORY AND AGE OF ONSET

	AGE OF ONSET	RELATIONSHIP
☐ CANCER (including type)	_____	_____
☐ DIABETES (please indicate if TYPE 1 or 2)	_____	_____
☐ HEART ATTACK/STROKE	_____	_____
☐ HYPERTENSION/HIGH BP	_____	_____
☐ OTHER	_____	_____

PLEASE LIST ANY MEDICATION YOU ARE CURRENTLY TAKING, including the dose and quantity, and whether in liquid/tablet/capsule/patch form:

EXERCISE: ☐ LIGHT ☐ MODERATE ☐ HEAVY

ALCOHOL: NO. OF UNITS//WEEK: _____

CARERS:

Do you look after someone?, YES/NO

Does someone look after you? YES/NO

If someone looks after you, and you would like us to know their name please write it here and include their name/address/phone number…….

Do you have a "Living Will" (a statement explaining what medical treatment you would not want in the future?	Yes/No	If Yes- please bring a written copy to your New Patient Consultation
Have you nominated someone to speak on Your behalf (e.g a person who has Power Of Attorney)?	Yes/No	If Yes, please state their contact details

Specific Needs: Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:	
Please state any Sensory Impairment you have (i.e. Speech, Hearing, Sight):	
Are you an 'Assistance Dog' User?	
Please state any Physical disabilities you have:	
Please state any Mental disabilities you have:	
Please state any requirements you have to be able to access the Practice premises	
Please state any Religious or Cultural needs:	
Do you require the help of a Translator / Interpreter?	
Please state any specific nutritional requirements you have:	

Please state any allergies and sensitivities you have:	
Please state any phobias you have:	

Patient Participation Group

Patient Participation Group The Practice is committed to improving the services we provide to our patients. To do this, it is vital that we hear from people about their experiences, views, and ideas for making services better. By expressing your interest, you will be helping us to plan ways of involving patients that suit you. It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice. If you are interested in getting involved, please tick the box below and we will arrange someone to contact you about this.	
Yes, I am interested in becoming involved in the Practice Patient Participation Group (Please tick the "Yes" Box)	Yes

Summary Care Record

SCRs contain essential health information about any medicines, allergies and adverse reactions derived from a patient's GP record. SCRs can be accessed electronically by healthcare staff providing care to a patient in an urgent or emergency care setting, anywhere in England, any time of day or night. SCRs provide access to information held on GP clinical systems about, as a minimum, a patient's medicines, allergies and any past drug reactions. The Summary Care Record is helping to improve safety, and the quality and continuity of care to patients.

Our practice has now activated the SCR function.

Benefits to NHS staff

- Essential patient information is available in an emergency situation.
- Key information in an SCR enables clinicians to make informed decisions to treat patients.
- Risk of medication duplication or conflict is minimised.

Benefits to patients

- Appropriate care received in an emergency.
- Faster assessments.
- No need to repeat information to different members of staff.
- Better, safer prescribing.
- Information is instantly available to clinicians for vulnerable people and those with communication difficulties.
- Additional information – such as end of life care plans and relevant diagnoses – may be available to inform clinical care.

Options: please confirm

Express consent for medication, allergies, and adverse reactions only	YES / NO
Express consent for medication, allergies, adverse reactions and additional information	YES / NO
Express dissent (opted out) - Patient does not want a Summary Care Record	YES / NO

Signature…… Date……..