GROVELANDS & GRENOBLE MEDICAL CENTRE

1 Grovelands Road
Palmers Green, London. N13 4RJ
Tel: 0208 882 4556 Fax: 0208 882 8810
Website: http://www.gpdoctor.co.uk/
Email: gpdoctor@nhs.net

Branch site
7 Natal Road
New Southgate. N11 2HU
Tel: 0208 881 6848 Fax: 0208 881 6811

Branch site
1 Grenoble Gardens,
Palmers Green. N13 6JE
Tel: 020 8889 5423 Fax: 020 8881 4656

NEW PATIENT REGISTRATION QUESTIONNAIRE

Please complete as fully as possible as this information is used to improve your care.

All information is kept strictly confidential.

PATIENT DETAILS

*Title Mr ☐ Mrs ☐ Miss ☐ Dr ☐ Other ☐

*Surname: _____ *Forename: _____

*Date of Birth: _____ *Email: _____

*Address: _____

*Post Code: _____ *Home Telephone:_____ *Mobile: _____

*** CONSENT**

Do you want your medical record uploaded? Yes ☐ I GIVE MY CONSENT NO ☐ I DO NOT GIVE MY CONSENT
(Summary Care Record – collect leaflet from the reception for further information) (If NO please complete the OPT-OUT FORM)

Do you want your medical record extracted? Yes ☐ I GIVE MY CONSENT NO ☐ I DO NOT GIVE MY CONSENT
(Care.data – collect leaflet from the reception for further information) (If NO please alert the reception staff for more information)

All registered patients at Grovelands and Grenoble MC have a named, accountable GP who is responsible for patients' overall care at the practice. You will be allocated with a Named GP. If you wish to know your allocated GP is please contact the practice after your registration.

Yes ☐ I have read the above and understand, if I have any questions I will contact the practice.

***ONLINE ACCESS TO MEDICAL RECORD**

If you wish to have access to your medical record online –you can either download & install NHS App from the AppStore and GooglePlay Or speak to reception staff for more information.

***NEXT OF KIN**

Name: _____ Contact telephone: _____

Relationship to patient (e.g. wife, husband, mother, father, son, daughter, niece, nephew, friend, neighbour) _____

Can we contact the above-mentioned person on an Emergency? Yes ☐ No ☐

Can we discuss your Medical Record with the above-mentioned person? Yes ☐ No ☐

***REGISTRATION STATUS**

Have you registered with this practice before? Yes ☐ No ☐

Have you registered with any of our Doctors PRIVATELY before? Yes ☐ No ☐

***NOTIFICATION PREFERENCES**

Do you consent to receive SMS notifications for clinical services? Yes ☐ No ☐
Do you consent to receive email notifications for clinical services? Yes ☐ No ☐

CARER INFORMATION

Are you a carer? (Do you look after a friend or relative who is sick, disabled, elderly or for any other reason)

If yes, who are you caring for: _____

Do you yourself have a carer? (as defined above) Carer's name & contact number: _____
_____

mandatory field please

*** ETHNICITY**

☐ White British	☐ Caribbean	☐ Chinese
☐ White Irish	☐ African	☐ Turkish
☐ White Other	☐ Black Other	☐ Greek
☐ White and Black Caribbean	☐ India	☐ Romanian
☐ White and Black African	☐ Pakistani	☐ Other Group
☐ White and Asian	☐ Bangladeshi	☐ Information Refused
☐ Mixed other	☐ Asian Other	

***FIRST LANGUAGE**

☐ Albanian	☐ Greek	☐ Polish	☐ Turkish
☐ Africana	☐ Hindi	☐ Portuguese	☐ Twi
☐ Arabic	☐ Igbo	☐ Punjabi	☐ Urdu
☐ Bengali	☐ Italian	☐ Romanian	☐ Yoruba
☐ Bulgarian	☐ Japanese	☐ Russian	☐ Other (please specify below)
☐ Cantonese	☐ Kurdish	☐ Somalia	
☐ English	☐ Lithuanian	☐ Swahili	
☐ Farsi	☐ Mandarin	☐ Swedish	
☐ French	☐ Oromo	☐ Thai	
☐ German	☐ Panjabi	☐ Tibetan	

Occupation/Armed Forces

Occupation: _____Veteran of the Armed Forces: _____

***SMOKING Please complete:**

☐ Never smoked

☐ Current smoker: No per day_____

☐ Ex-Smoker [Date stopped: _____]

I would like help and advice on giving up ☐

Type of Tobacco

☐ Cigarettes

☐ Cigars

☐ Roll ups/pipe

***ALCOHOL**

How many units of alcohol do you drink in an average week? _____ units

(e.g. 1/2 glass wine = 1 unit, 1 pint beer = 2 units, 1 measure spirit = 1 unit) – please state "0" if not applicable

BMI & Blood Pressure Reading – (Please use the monitoring machine in the Waiting Area)

Weight: _____ kg Height: _____cm BMI: _____

Blood Pressure: _____ / _____ Pulse: _____

EXERCISE

Mild ☐ Moderate ☐ Regular ☐ Type of exercise: _____

DIET

Vegetarian ☐ Vegan ☐ Gluten-free ☐ Kosher ☐ Others _____

*** ALLERGIES**

Do you have any allergies?

Pollen (hay fever) ☐ Medicine e.g. penicillin ☐ Nuts ☐ Dairy ☐ Other ☐

If you tick any of the above please give details below:

_____

***YOUR MEDICAL HISTORY:**

Do you suffer from any of the following medical conditions, please complete the table below

mandatory field please

Medical condition	Yes/No	First Diagnosed	Medication
Stroke			
Angina			
Heart Attack			
Diabetes			
High Blood Pressure			
Cancer			
Asthma			

***YOUR FAMILY HISTORY:**

Do any of your family (<u>not</u> yourself), suffer from any of the following medical conditions, if yes, please state which family member and at what age they were diagnosed.

Medical condition	Yes/No	Family Member	Age at diagnosis
Stroke			
Angina			
Heart Attack			
Diabetes			
High Blood Pressure			
Cancer			
Asthma			

This is one unit of alcohol…

…and each of these is more than one unit

FAST	**Scoring system**					**Your score**
	0	**1**	**2**	**3**	**4**	
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	
Only answer the following questions if the answer above is Never (0), Less than monthly (1) or Monthly (2). Stop here if the answer is Weekly (3) or Daily (4).						
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 been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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	

mandatory field please

Scoring:
If score is 0, 1 or 2 on the first question continue with the next three questions

If score is 3 or 4 on the first question – stop here.
An overall total score of 3 or more is FAST positive.
What to do next? Book an appointment with one of our practice Nurses.

FOR WOMEN ONLY

Cervical Smear Information

Date of last smear test: _____ Result: _____

Where was it performed? Last GP surgery ☐ Family Planning Clinic ☐ Abroad ☐ _____

Hysterectomy **(If applicable)**

Date: _____ Do you require any further smears? Yes ☐ No ☐

Where was it performed? Hospital ☐ _____ Abroad ☐ _____

Mammogram

Have you had a mammogram? Yes ☐ No ☐ Date: _____

Where was it performed? Hospital/Clinic ☐ _____ Abroad ☐ _____

Result: _____

*Patient Contract

Dear Patient,

Thank you for registering with Grovelands Medical Centre. We aim to provide a high standard of service to all of our patients. In order for us to maximise the service we are able to give, we request that patients agree to a number of practical measures:

- To endeavour to attend appointments punctually and to cancel any appointment with plenty of notice when unable to attend.
- To check in at the reception desk upon arrival in the building.
- To note that home visits are only for housebound patients or patients who are too ill or frail to attend surgery. The Doctor will always assess the situation first before making a decision to visit.
- To use the Out of Hours service only if the problem cannot wait until morning. This means **genuine urgent matters** only.
- To request an urgent appointment **only** for he treatment of **genuine urgent matters** that requires immediate medical treatment. This means you must not request that routine matters be considered within these consultations.
- To only attend Accident & Emergency for accidents or real emergencies, not for minor ailments or routine medical reasons.
- To endeavour to do whatever possible to take responsibility for, and improve, your own health.
- To inform the practice of any changes in name, address or telephone numbers.
- To order your prescriptions in plenty of time so that you do not run out. To understand that 48 hours notice is required for prescription request and that must be requested in writing, **not** over the telephone.
- To adhere **to zero tolerance of abuse toward all staff**. To agree **not** to behave in an abusive, threatening or aggressive manner with any member of practice staff.

I _____ confirm that all information given is correct and completed to the best of my ability.
Full name

_____ _____
Signature Date

mandatory field please