

KING EDWARD ROAD SURGERY

A very warm welcome to our Surgery, and thank you for registering with us.

We ask all new patients to complete this form, for two main reasons:

1. It will take 6 to 8 weeks for your medical records to be transferred from your previous surgery. The details you give us about your current state of health will assist us ensuring we understand from the outset any requirements you will have.
2. This information you provide ensures we have all your personal details entered on our computer system, such as phone number, next of kin etc.

Please take your time to complete as much of the information as possible.

When you hand the form back to our Receptionist she will check the form, and give you a New Patient Leaflet.

This leaflet gives you an overview of the Surgery, and further information can be found on our web site – www.kers.org.uk

As a new patient you maybe interested in joining our Patient Participation Group. The Patient Participation Group is open to all registered patients and works with the Surgery, via a small Management Committee.

If you are interested in further details please ask our Receptionist, who will give you a leaflet and contact details for the Chairperson.

The Doctors, nurses and all staff are committed to the provision of High Quality Patient Care and best practice, through the delivery of services which are timely, considerate and responsive to the needs of our patient population, and supported by a clear focus on customer service.

PATIENT HEALTH QUESTIONNAIRE

Patient's Details

Title		Surname	
Date of Birth		First names	
Occupation		Previous surnames	

Home Address									
Postcode	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">Home Tel</td> <td></td> </tr> <tr> <td>Work Tel</td> <td></td> </tr> <tr> <td>Mobile</td> <td></td> </tr> <tr> <td>Email</td> <td></td> </tr> </table>	Home Tel		Work Tel		Mobile		Email	
Home Tel									
Work Tel									
Mobile									
Email									

By giving us your mobile phone number and your e-mail address you consent to us contacting you by either of these methods.

What is your first language?	
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Ethnic Group

White	British <input type="radio"/> / Irish <input type="radio"/> / Other :
Black	Caribbean <input type="radio"/> / African <input type="radio"/> / Other :
Asian	Indian <input type="radio"/> / Pakistani <input type="radio"/> / Chinese <input type="radio"/> / Other :
Mixed	White & Black Caribbean <input type="radio"/> / White & Black African <input type="radio"/> / White & Asian <input type="radio"/> / Other : Information Refused <input type="radio"/>

Proof of Identity and Address Provided?

Birth Certificate <input type="radio"/>	Driving Licence <input type="radio"/>	Passport <input type="radio"/>	Utility Bill <input type="radio"/>
Allowance Book <input type="radio"/>	Solicitor's Letter <input type="radio"/>	Offer of Tenancy <input type="radio"/>	Other:

Medical Information

Please list any serious illnesses/operations/accidents/disabilities (and for women any pregnancy related problems) and the year they took place:
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Have you suffered from? (tick as appropriate)	
Epilepsy <input type="radio"/>	Blindness/Glaucoma <input type="radio"/>
High Blood Pressure <input type="radio"/>	Diabetes <input type="radio"/>
Heart Attack/Stroke <input type="radio"/>	Depression <input type="radio"/>
Cancer <input type="radio"/>	Asthma <input type="radio"/>
Eczema/Hay Fever <input type="radio"/>	COPD <input type="radio"/>

Please list any medicines being taken and the amount:	
Are you registered disabled? (If yes, please give details)	Yes <input type="radio"/> No <input type="radio"/>
Are you allergic to any medicines and if so, which?	Yes <input type="radio"/> No <input type="radio"/>
Have you ever refused treatment/screening of any kind and if so, what?	Yes <input type="radio"/> No <input type="radio"/>

Other Information

Carers	
Do you look after someone who is ill, frail, disabled or mentally ill? (If yes who)	Yes <input type="radio"/> No <input type="radio"/>
Does someone look after you? (If yes who)	Yes <input type="radio"/> No <input type="radio"/>

Smoking	
Do you smoke?	Yes <input type="radio"/> No <input type="radio"/>
If "No", have you ever smoked? Yes <input type="radio"/> No <input type="radio"/> If Yes Date stopped:	
If you do currently smoke, how many cigarettes or ounces of tobacco do you smoke per week?	
Would you like advice on giving up smoking?	Yes <input type="radio"/> No <input type="radio"/>

What is Your Height?
What is Your Weight?
What is Your Blood Pressure?

Family History

Please state any serious illness, in particular heart disease, strokes, high blood pressure, diabetes or any inherited disease:

Alcohol - How much do you drink? (AUDIT C)

UNITS



Pint of Regular Beer/Lager/Cider



Alcopop or Can of Lager



Glass of Wine (175ml)



Single Measure of Spirits



Bottle of Wine

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink that contains alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring: A total of 5+ indicates hazardous or harmful drinking

If you require advice regarding your alcohol consumption - please ask at reception

Please give name, relationship, address and telephone number of next of kin

For Patients aged 65 and over or those with a chronic disease (e.g. asthma or diabetes)

Have you had a flu vaccination? (Enter date or never)	
Have you had a pneumococcal vaccination? (Enter date or never)	

For Patients aged 18 or under only

This Practice actively supports Child Protection Policies in Northamptonshire which requires us to record whether you (if over 16 but under 18) or this child (if under 16) has ever had a Social Worker involved with your family?	YES/NO
Please provide the name of the school/nursery attended	

Signature	Date

Please tick to register for on-line ordering of repeat medication and appointment booking

For practice use only

ID seen: Yes No

Address Confirmed: Yes No