

Registration Form

Please write clearly to avoid any delay in your registration

Personal Details								
Title:	<input type="checkbox"/> Mr	<input type="checkbox"/> Miss	<input type="checkbox"/> Mrs	<input type="checkbox"/> Ms	<input type="checkbox"/> Dr	Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female
First Name :				Surname:				
Date of Birth:				NHS Number:				
Home Address:								
Postcode:			Home No:			Mobile No:		
Email:				Occupation:				
Country of Birth:				Town of Birth:				
If born in London, please state the borough you were born in:								
Have you had a GP in the UK?	<input type="checkbox"/> Yes <input type="checkbox"/> No		If no please provide the date you entered the UK:					
Name of previous GP surgery & postcode:								
Next of Kin Details								
Full Name				Relationship to you:				
Home No:				Mobile Number:				
Ethnicity & Language								
Please select your ethnic group:	<input type="checkbox"/> White British	<input type="checkbox"/> White Irish	<input type="checkbox"/> Other White Ethnic Group					
	<input type="checkbox"/> Pakistani	<input type="checkbox"/> Indian	<input type="checkbox"/> Bangladeshi					
	<input type="checkbox"/> Chinese	<input type="checkbox"/> Other Asian Ethnic Group	<input type="checkbox"/> Black African					
	<input type="checkbox"/> Black Caribbean	<input type="checkbox"/> Other Black Ethnic Group	<input type="checkbox"/> Black African & White					
	<input type="checkbox"/> Black Caribbean & White	<input type="checkbox"/> Asian & White Mixed						
Main Language:				Do you require an interpreter?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Carer Details								
Do you have a carer?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Are you a carer?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Carers Name:				Name of person you care for:				
Carers Address:				Their address:				
Contact Number				Contact Number				
Smoking & Alcohol								
Smoking Status:	<input type="checkbox"/> Never Smoked			Type of Smoker :	<input type="checkbox"/> Cigarette Smoker			
	<input type="checkbox"/> Current Smoker				<input type="checkbox"/> Cigar Smoker			
	<input type="checkbox"/> Ex-Smoker Date stopped: _____				<input type="checkbox"/> Pipe Smoker			
If current or ex-smoker please state how many smoked per day:								
Would you like to be referred to the Stop Smoking Service?				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				
Alcohol Status:	<input type="checkbox"/> Current Drinker		How often do you have a drink containing Alcohol?	<input type="checkbox"/> Never		<input type="checkbox"/> Monthly or Less		
	<input type="checkbox"/> Ex-Drinker			<input type="checkbox"/> 2 - 4 times a month		<input type="checkbox"/> 2 - 3 times a week		
	<input type="checkbox"/> Never Drunk Alcohol			<input type="checkbox"/> 4 or more times a week				
How many units of alcohol do you drink on a typical day when you are drinking?	<input type="checkbox"/> 1 or 2 <input type="checkbox"/> 3 or 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?	<input type="checkbox"/> Never				
	<input type="checkbox"/> 5 or 6 <input type="checkbox"/> 7 or 8			<input type="checkbox"/> Less than monthly				
	<input type="checkbox"/> 10 or more			<input type="checkbox"/> Monthly				
				<input type="checkbox"/> Weekly				
				<input type="checkbox"/> Daily or almost daily				
Medical History								

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Do you or have you suffered from any of the following?	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy
	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cancer	<input type="checkbox"/> Pneumonia
Please list any medication you take:	<input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/>		
Are you allergic to any medication? If yes please state:	<input type="checkbox"/> Yes Medication name: <input style="width: 80%;" type="text"/> <input type="checkbox"/> No		
Are you allergic to anything else? If yes please state:	<input type="checkbox"/> Yes Allergic to: <input style="width: 80%;" type="text"/> <input type="checkbox"/> No		

Family History

Does anyone in your family suffer from (present/ in the past) any of the following health problems, if so please indicate their age in the table below?

	Mother	Father	Aunt	Uncle	Grandmother	Grandfather	Sister	Brother
Heart Attack								
Diabetes								
Stroke								
Asthma								
High Blood Pressure								
Cancer								

Vaccination History *Please provide a copy of immunisation records including travel vaccinations*

Please provide details of any vaccinations you have had:

Vaccination	Date Given	Where was it given?

Online Services

In order to access a range of on-line services including appointment making, repeat prescription requests and to view a summary of your records please tick here **NB Photo-ID required.**

Text message Services

We sometimes send appointment text message reminders so please let us know if you would prefer us not to.

Would you like to receive text message reminders? Yes No

Patient signature:	<input style="width: 100%;" type="text"/>	Date completed:	<input style="width: 100%;" type="text"/>
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FOR SURGERY USE ONLY

Proof of address checked & address confirmed	<input type="checkbox"/> Yes <input type="checkbox"/> No	Checked by:	<input style="width: 100%;" type="text"/>
Photo ID verified	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Date registration added to System One:	<input style="width: 100%;" type="text"/>	Added by:	<input style="width: 100%;" type="text"/>

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FEMALE ONLY SECTION			
Personal Details			
Title:	<input type="checkbox"/> Mr <input type="checkbox"/> Miss <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Dr	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
First Name :		Surname:	
Date of Birth:		NHS Number:	
Pregnancies			
How many times have you been pregnant?		How many deliveries have you had?	
What type of deliveries have you had? e.g. normal, C-section etc.			
Any problems experienced during pregnancy?			
Cervical Screening <i>IT IS VERY IMPORTANT THAT YOU COMPLETE THIS SECTION SO THAT WE HAVE AN ACCURATE SMEAR RECORD FOR YOU</i>			
Date of last cervical smear test:		Where was the test taken?	<input type="checkbox"/> GP <input type="checkbox"/> Hospital <input type="checkbox"/> Abroad <input type="checkbox"/> Private <input type="checkbox"/> Family Planning Clinic <input type="checkbox"/> Other
What was the result?	<input type="checkbox"/> Normal, routine recall – 3 years <input type="checkbox"/> Abnormal <input type="checkbox"/> Normal, early recall – 1 years <input type="checkbox"/> Borderline changes, recall – 6 months <input type="checkbox"/> Normal, early recall – 6 months <input type="checkbox"/> Inadequate, recall – 3 months		
Have you ever had an abnormal smear?	<input type="checkbox"/> Yes If yes, when? _____ <input type="checkbox"/> No		<input type="checkbox"/> I do not require a smear test as I have never been sexually active
<i>For more information regarding smears please speak to one of our nurses</i>			
Hysterectomy Details			
Have you ever had a hysterectomy?	<input type="checkbox"/> Yes If yes, when? _____ <input type="checkbox"/> No		
If yes, which of the following?	<input type="checkbox"/> Total Hysterectomy (the womb and cervix (neck of the womb) are removed) <input type="checkbox"/> Subtotal Hysterectomy (the main body of the womb is removed, leaving the cervix in place) <input type="checkbox"/> Total Hysterectomy with bilateral salpingo-oophorectomy (the main body of the womb is removed, leaving the cervix in place) <input type="checkbox"/> Radical Hysterectomy (the womb and surrounding tissues are removed, including the fallopian tubes, part of the vagina, ovaries, lymph glands and fatty tissue)		
Contraception			
Do you currently use contraception? If yes please state which one	<input type="checkbox"/> Yes Please state: _____ <input type="checkbox"/> No		
Mammogram			
When did you last have a mammogram?	<input type="checkbox"/> Never		
Patient signature:		Date completed:	

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NHS
*Hammersmith and Fulham
Clinical Commissioning Group*

Sharing your medical information

Your choices

Health professionals are trained to keep your records secure and to manage them responsibly and in confidence.

Your GP can now see your medical record held in other health organisations that provide your care e.g. your hospital or health centre. Health professionals e.g. your hospital doctor, district nurse, or physiotherapist treating you can also see your full GP record if you give your permission when they see you.

Sharing your records benefits you because:

- You won't need to repeat your medical history.
- You avoid unnecessary appointments and tests.
- Your health professional has the right information at the right time.

Please enter your name and dob and select one option for 1) and 2)

Name: Date of Birth:

1) Your practice sharing your record with other healthcare organisations

Yes, I am happy for my GP practice to share my full medical record with other organisations providing my care.

No, do not share my medical records with other organisations.

N.B. Selecting no might delay your treatment or mean repeated tests. Professionals and emergency departments will not have up to date information about you.

2) GP practice seeing your record from other healthcare organisations

Yes, I am happy for the GP practice to see records held about me by other organisations providing my care.

No, I do not want the GP practice to see records held about me by other organisations.

N.B. Selecting No means that your GP might not have up to date information from other organisations to continue caring for you safely. Mistakes could be made because your information from other organisations is not joined up.

For more information:

Click: <http://www.hammersmithfulhamccg.nhs.uk/what-we-do/your-patient-record>

Call: 0800 881 5209

Email: sharing.information@nhs.net

Ask: staff at your GP practice

For practices Use Only: Set share out & share in preferences on SystemOne