Shoreditch Park Surgery Registration Form

Name……..

Telephone Number……..

Ethnic Group……..

Language Spoken……..

Interpreter Needed? Yes / No

Smoking Status (please tick)

Smoker…….How many a day…….

Occasional Smoker……..

Ex Smoker (Quit date)…….

Would like help quitting now?……..

Never Smoked……..

Next of Kin (must be a resident of the UK)

Mr / Mrs / Miss / Ms (please circle)

First name..…… Surname……...

Relationship…….

Telephone Number……..

Please let us know if you have any additional or communication needs due to disability,

Impairment, or sensory loss :……..

Please let us know how we can help and if any of the following would be useful to you:

☐Braille ☐ Easy Read information and letters ☐ An Advocate

☐ Large Text information and letters ☐British Sign Language interpreter

-

We currently have a hearing loop installed within the surgery which will help our patients who use hearing aids

Children:

Which school do you attend?……..

Summary Care Record: Opt in / Opt out	Summary Care Record Additional Information: Opt in/ Opt out
Data Sharing: Opt in / Opt out	

Please name all other members of your household registered with this practice:

Name	Date of Birth

Family Medical History

Is there any of the following in your immediate family (father, mother, brother, sister) before the age of 60? *(please circle yes or no)*

Asthma Yes / No

Hypertension Yes / No

Heart Disease Yes / No

Diabetes Yes / No

Stroke Yes / No

Cancer Yes / No

Other *(please state)*……

Personal Medical History

Height (*if known)*…… Weight *(if known)*…….

Do you or have you suffered from any of the following? *(please circle yes or no)*

Hypertension	Yes / No	Blindness/Glaucoma	Yes / No
Heart Disease	Yes / No		
Stroke	Yes / No	COPD	Yes / No
Asthma	Yes / No	Eczema	Yes / No
Diabetes	Yes / No	Epilepsy	Yes / No
Cancer	Yes / No	Anxiety	Yes / No
Depression	Yes / No	OCD	Yes / No
Bipolar Disorder	Yes / No	Other (*please specify*)……	

If yes, please state the year(s) you were diagnosed……..

Do you have any allergies? Yes / No

If yes, please state……**.....**

Women Only

Last smear test?...../...../..... Result…….

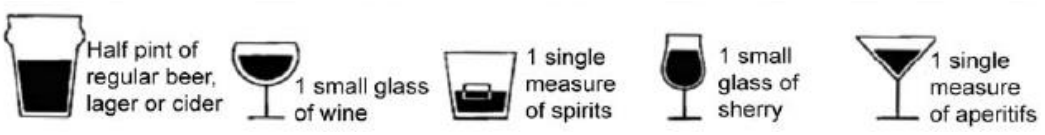
If abnormal, have you ever been referred to Colposcopy? When……. Where……..

Do you use any form of contraception? Yes / No

If yes, please state …….

Any previous pregnancies?.....

This is one unit of alcohol…



…and each of these is more than one unit

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
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	
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+	
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	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

What is Patient Access?

With Patient Access, you can now access your local GP services at home, work or on the move – wherever you can connect to the internet. What's more, because Patients Access is a 24 hour online service you can do this in your own time, day or night

Please give us your details below if you wish to opt in for Patient Access

First Name:

Last Name:

Date of Birth:

Email:

Postcode:

Once we have entered your details on to our system you will receive an email from 'emisnotify@emishealth.com' within five working days.

The email will have a step by step guide on registering as well as your own unique log in codes.