The Lyndhurst Surgery
53 Lyndhurst Drive, Leyton, London, E10 6JB
Tel no: 020 8539 1663 - Fax: O20 8556 1977

Patient Questionnaire

Failure to notify change of Address/ Tel. & No Response to recall letters may lead to Automatic Deregistration.

The following information will help us provide better care for you: (Please fill in all information stating N/A where applicable!)

Surname: Forename: Date of birth:

Male / Female: .Town & Country of birth:

Present address:

Tel No: Email address:

Marital Status: Present Occupation:

Next of Kin Details:

Would you like practice to send you sms messages? YES ☐ NO If yes, Mob No:

Any family member registered with Practice: (Please circle) YES ☐ NO ☐ (If yes please give details)

Family member name: DOB:

Relation: Address:

NAMED ACCOUNTABLE GP FOR ALL PATIENTS

You may be aware that from April 2015 all practices are required to provide all their patients with a named GP who will have overall responsibility for the care and support that our surgery provides to them.

Dr P Goel - Named GP for all female patients under 75 years **&** ***Dr H Johal - Named GP for all male patients under 75 years***

If you wish to change your allocated named GP please contact reception staff.
Having an allocated GP does not prevent you from seeing any GP in the practice as you currently do

Would you like to have a Summary Care Record? YES ☐ NO ☐

IF YES PLEASE SELECT THE FOLLOWING:

☐ Express consent for medication, allergies and adverse reactions only

☐ Express consent for medication, allergies, adverse reactions and additional information

Summary care Record is an electronic record of important information about your health. It will only be available to authorised healthcare staff providing your NHS care in England. This means if you ever had an accident or become ill and need urgent or out of hour's advice or treatment, the clinicians treating you can have immediate and secure access to important information about you which will include:

1) Current Medication 2) Allergies 3) Adverse reactions to medicines you may have had

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MEDICAL HISTORY:

DRUGS: YES ☐ NO ☐

If yes please list any medicines or tablets you are taking at present. Failure to do so will delay your registration process

1. **3.** **5.**
2. **4.** **6.**

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Past Operations:

Current Smoking Status: Never smoked ☐ Ex-smoker ☐ Cigarette smoker☐ /day

Alcohol consumption: NO☐ YES☐ (If yes please fill the Alcohol Screening Questionnaire on last page)

PAST MEDICAL HISTORY: Please circle.

☐ Epilepsy ☐ Blood Pressure ☐ Diabetes ☐ Heart Attack

☐ Stroke ☐ Asthma ☐ Eczema ☐ Hay Fever

☐ Cancer ☐ TB Allergies:

FAMILY HISTORY:
Do any of your family have or had any of the following illness or conditions? Please tick.

☐ Diabetes	☐ High Blood Pressure	☐ Stroke	☐ Nervous Disorders
☐ Heart Attack	☐ Epilepsy or fits	☐ Asthma	☐ Migraine
☐ Cancer	☐ Eczema	☐ Mental Health	☐ Depression

FEMALES: (Please select)
Are you pregnant? YES ☐ NO☐ If yes how many weeks are you? ……..
Have you, or do you attend a Family Planning Clinic. Yes ☐ No☐
Do you use the: PILL ☐ CONDOM ☐ CAP☐ COIL☐ NOTHING☐
If you are on the Pill (oral contraception), which one do you take……..……..
If you are fitted with a coil, when was it fitted…….…….
Have you ever had any complication of pregnancy Yes☐ No☐
When did you last have a cervical smear? ……
Where did you have your last smear? GP Surgery☐ Clinic☐

IMMUNISATION HISTORY: - for children who are Fourteen years old and under.
Please provide the copy of the childhood immunisation

Other Vaccinations in the past?

Career details for Children /Elderly/ Infirm:

INFORMATION ABOUT YOURSELF

Do you Speak English? YES ☐ NO ☐ Main spoke language/s? .....

Do you have a disability/any special requirement that we need to take into account? Y☐ / N☐
If yes please give details
If you have a disability/any special requirements please select your preferred communication method?

TELEPHONE ☐ LETTER ☐ TEXT MESSAGE ☐

For any other communication method please provide details?

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Are you a carer? (Do you look after a friend or relative who is sick, disabled, elderly, who has mental health problems or for any other reason) YES ☐ NO ☐

Do you yourself have a carer? (Defined above) YES ☐ NO ☐

Are you a refugee or an asylum seeker? YES ☐ NO ☐

Which ethnic group do you feel you belong to? (Please tick)

☐ Asian - British	☐ Indian	☐ Black - African	☐ White - African
☐ Black - British	☐ Pakistani	☐ Caribbean	☐ White
☐ White - British	☐ Bangladeshi	☐ Black - Other	☐ Arabic
☐ Mixed - British	☐ Chinese	☐	☐ Mixed
☐ Any other Asian ethnic identity: *(please give details)*	☐ Any other black ethnic identity: *(please give details)*	☐ Any other white ethnic identity: *(please give details)*	☐ Any other ethnic identity: *(please give details)*

ONLINE PATIENT ACCESS:

You will have access to online appointments booking after your registration checkup. To have access to online repeat prescriptions, medical records or for more information, please ask at reception.

Our Patient Participation Group is encouraging patients to give their views.

Would you like to participate? YES ☐ NO ☐

If yes please provide your Email Address:

All prospective new patients to note:
The Lyndhurst Surgery is run on an appointment system. Emergency appointments are only given to patients suffering from severe ailments, i.e. chest pain, difficulty in breathing, bleeding problems, children with acute problems. All other problems should be dealt with the next available appointment.
Registration / Confirmation of Acceptance are subject to Registration check-up.
Sample of urine will be required on registration check.

Documents require for registration:

1) Copy of your photo ID or Copy of your visa if applicable
   &
2) Copy of proof of address (copy of bank statement/bill/or any other document with name & address)
3) Copy of the child immunisation for any child under 14 years of age

Patient Signature: Date:

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Alcohol screening - FAST

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?

☐ 0 points = Never
☐ 1 point = Less than monthly
☐ 2 points = Monthly
☐ 3 points = Weekly
☐ 4 points = 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?

☐ 0 points = Never
☐ 1 point = Less than monthly
☐ 2 points = Monthly
☐ 3 points = Weekly
☐ 4 points = 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?

☐ 0 points = Never
☐ 1 point = Less than monthly
☐ 2 points = Monthly
☐ 3 points = Weekly
☐ 4 points = 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?

☐ 0 points = No
☐ 2 points = Yes, but not in the last year
☐ 4 points = Yes, during the last year

Thank you for completing this form.

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