TOWNFIELD DOCTORS SURGERY

Dr S Thankappan, Dr S Babu, Dr J Zelamal, Dr A Ramasamy
34 College Way
Hayes, Middlesex UB3 3DZ
Tel: 020 8573 5856 Fax: 020 8756 4461

Dear Patient

The Primary Care Trust is working to make services better for all. We know that different ethnic groups have differing medical needs. By answering the questions on the next page of this letter, you will be helping us to deliver better services to you as an individual. The important information you provide will help us get a better picture of our local population which will help the planning of new services and changes to existing ones.

As always any information you provide will be treated in the strictest confidence. Only NHS staff will use individual information. The details you give will be treated exactly the same way as any other information we hold.
When the data is used for planning services, all names and other identifying details will be removed.

We apologise if you have been asked to complete this type of form by other areas in the NHS but our information system here at the practice is separate from that of the Hospital Trusts.

Ethnic Category Questionnaire

What is your Ethnicity?

White: English/Welsh/Scottish/Northern Irish/British	
White: Irish	
White: Gypsy or Irish Traveller	
White: Any other White background	

Mixed/Multiple ethnic groups: White and Black Caribbean	
Mixed/Multiple ethnic groups: White and Black African	
Mixed/Multiple ethnic groups: White and Asian	
Mixed/Multiple ethnic groups: Any other Mixed/Multiple ethnic background	

Asian/Asian British: Indian	
Asian/Asian British: Pakistani	
Asian/Asian British: Bangladeshi	
Asian/Asian British: Chinese	
Asian/Asian British: Any other Asian background	

Black/African/Caribbean/Black British: African	
Black/African/Caribbean/Black British: Caribbean	
Black/African/Caribbean/Black British: Any other Black/African/Caribbean background	

Other ethnic group: Arab	
Other ethnic group: Any other ethnic group	

Office use only
Form checked by ……Date……..Which Doctor?.....

If you would like this application form in an alternative format, for example large print or easy read, or if you need help with communicating with us, for example because you use British Sign Language, please let us know.

NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE

Please fill this in completely and honestly as it will form part of your legal medical record

Height:	
Weight:	
Residential Status:	**Lives alone (Key code number is necessary?)** **Lives with others Homeless** **Residential/Nursing Home**
Occupation:	
Any known allergies of food, material or medication	
Next of Kin (name, address, telephone number and relationship to you): **Consent to discuss medical record with next of kin?**	 **Yes No**

NON UK PATIENTS

If from abroad, are you entitled to NHS treatment (circle)? Yes No

If you are travelling from Europe, please provide the details of your EHIC health card:

Personal ID Number……

Card Number……..

CARER INFORMATION Definition of a carer: A carer is anyone, including children and adults who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support. The care they give is unpaid.

Are you a carer (circle)? Yes No

Do you have a carer (circle)? Yes No

If you have answered yes to the above, please complete a carer's form from front desk.

VACCINATIONS

Have you had your full course of Tetanus & Polio vaccines as a child (including the school-leaver dose)?
Yes No

ALCOHOL

Please answer each question by circling the answers which best apply to you:
(If you have answered 'never' to question 1 you need not answer questions 2 & 3)

Question	0	1	2	3	4
1. How often do you have a drink that contains alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per month	4+ times for week
2. 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+

3. How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

SMOKING

Never Smoked **Ex-Smoker** **Smoker**

If you smoke, how many Cigarettes/Pipes/Cigars (circle appropriate) do you smoke per day?.....
If you are ex-smoker, when did you stop smoking? ……..

Smoking Help Everybody knows that it's not easy to stop smoking, and most smokers restart after quitting. That mustn't put you off stopping. We are here to help, not judge.
If you engage with a local Stop Smoking Chemist, they will supply you with Nicotine replacement products, tailored to your needs and preferences. They will sort out the prescription with us. We will only prescribe if you are followed up and supported by a participating chemist, as that is the most effective way to quit.
If you wish to join a group or try the stop smoking tablets, you'll need to ring 0800 652 8019 (free from a landline) or 0208 812 7794 from a mobile.

PERSONAL MEDICAL HISTORY

Please tick or cross and provide a date for the most recent episode or diagnosis

Medical condition	✓ or X and date	Medical Condition	✓ or X and date
Heart attack		Thyroid (over or under active)	
Angina		Drug dependence	
Heart bypass surgery		Tuberculosis (TB)	
Diabetes (please state how this is controlled)		Glaucoma	
Stroke		Cataract removal	
Epilepsy		Deafness	
Atrial Fibrillation (irregular pulse)		Ulcerative colitis	
Asthma		Crohns	
Chronic bronchitis requiring inhalers		Colostomy	
Gall stones		Gout	
Parkinson's disease		Multiple Sclerosis	
Psoriasis		Pacemaker	
Gastroscopy or barium meal		Cancer (what area?)	
Deep vein thrombosis (DVT)		Pulmonary embolism	
Renal failure (kidneys)		Liver problems	
Hepatitis B		Arthroscopy of knee	
Severe Osteoarthritis		Joint replacements	
Osteoporosis		Rheumatoid Arthritis	

In the space below, please add any other conditions or procedures you have had that you feel is relevant

……

OPERATIONS: Please list any operations you have had and state the date each procedure took place:

……..

WOMEN ONLY

BIRTH CONTROL

Family Planning Status	✓ as appropriate
Condoms	
Contraceptive Pill	
Depot Injection	
Coil (please add date fitted)	
Sterilized	
Partner/Husband Vasectomy	
Infertile	
Actively trying to conceive	

CERVICAL SMEAR

Date of last Smear: …….
Was *that* smear normal? Yes No
If no, what was the result? ……...
Have you had any abnormal smears in last ten years? Yes No
Date next smear due: …… (usually 3 years, unless abnormal previous)

HYSTERECTOMY

Have you had a hysterectomy? Yes No
Date of hysterectomy? ……Did they remove both Ovaries? Yes No
Age at Menopause (ending of periods) ……

MAMMOGRAM

Have you recently had a Mammogram? Yes No
What was the date of the Mammogram? ……..
Was the Mammogram normal? Yes No
Please provide details of the findings ……

Do you have trouble holding your water (mild incontinence)? Yes No
Have you ever had an Ectopic Pregnancy? Yes No
Have you ever had Ovarian cysts? Yes No

LEARNING DIFFICULTIES OR DISABILITIES

Do you consider yourself to have a learning difficulty or disability? Yes No
If you answered 'yes' to the above question, please provide some further details below:

……..

……..

MENTAL HEALTH

Have you ever been diagnosed with a mental health condition? Yes No
If you answered 'Yes' to the above question, please provide some further details below:

…….

FAMILY HISTORY Tick the box if you have a Parent, Brother or Sister with any of the below:

Medical condition		Which Family Member?
Premature Heart Disease		
High Blood Pressure		
Glaucoma		
Cancer (Where)?		
Diabetes		
Deep Vein Thrombosis (DVT)		

MEDICINES

List all medications you take including contraception and inhalers.

Please note that we haven't the expertise to prescribe Valium/ Temazepam/ Dihydrocodeine or any other drugs of dependence.

Patients on such medication are referred to the local drug team: we are unable to prescribe such medication at all.

Medicine Name	Strength	Number of tablets taken per day

We send all medication electronically straight to the chemist, please let us know your preferred pharmacy.
…….

Warning Letters: If you receive a warning letter for abusing staff/ clinicians, please be aware that it might result in you taken off our list.

DNA (Did Not Attend) appointments:

By signing the form, you understand that if you DNA (Did Not attend) your appointments 4 times within 6 months' period, you will be taken off from the register.

PATIENT DECLARATION

I confirm that the above information is correct to the best of my knowledge and that this document will form part of my medical record.

Patient Signature: …… Date: …….

Patient's information and communication needs

All providers of NHS and local authority social care services are legally required to identify, record and meet your individual information/communication needs.

Preferred method of contact? Telephone Email Letter

Preferred method of communication e.g. BSL, deafblind manual? ……

Large print 18 Large print 22 Large print 26 Easy-read Audio CD Email

Other (specify) ……..

I don't know and need an assessment

Preferred language (and identify if an interpreter is required) ……..

PPG (Patient Participation Group)

Would you like to have your say? Join our Patient Participation Group to contribute ideas and give feedback and suggestions to improve patient experience. We meet quarterly to discuss campaigns, complaints and local issues facing patients. If you would like to join us, please add your email address below. You can join or leave at any time.

……..