All information is strictly confidential

*(Please complete form in **BLUE INK** if possible & **BLOCK CAPITAL LETTERS**)*

1. **Gender**: Male ☐ Female ☐
2. **Family Name/Surname:**
3. **Date of Birth**: dd__/mm__ /yyyy____
4. Title (Mr/Miss/Mrs/Ms): ___________________
5. **Given Name/Forename**: **6.** Middle Name (s):
7. Known As/Calling Name:
8. Previous Family Name/Previous Surname:
9. NHS Number: ☐☐☐☐☐☐☐☐☐☐ (10 digits long)
10. Marital Status: __________________

11. Ethnicity

British/Mixed British ☐	Indian/British ☐	White & Black Caribbean ☐
Other Mixed ☐	African ☐	Other White ☐
Pakistani/British ☐	White & Black African ☐	Chinese ☐
Irish ☐	White & Asian ☐	Bangladeshi/British ☐
Caribbean ☐	Other Black ☐	Other Asian ☐
Other ☐	If Other please specify ________________________	

12. Main Spoken Language**:** ____________________

13. Will you require an Interpreter? Yes ☐ No ☐

Accessible Information

14. Please indicate if you have any of the following communication needs?

a) Registered blind or partially sighted ☐
b) Have a visual impairment ☐
c) Registered deafblind ☐
d) Registered deaf ☐
e) Have hearing difficulties ☐
f) On the learning disabilities register ☐
g) Other ☐ ________________________________

14a If you have any of the above please tell us how we can meet your communication needs ________________________________

15. Do you give consent for your information to be shared with other NHS and adult social care providers? Yes ☐ No ☐

Current Address in London

16. House Name/Flat Number: ____
Number & Street: ____
Town: _____________County: _________________Postcode: _______________

Contact Details

17. Home Tel Number:	**18.** Mobile Number:

19. Email Address: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

(Please provide us with the e-mail address you use most frequently)

Previous Home Address in the UK

20. House Name/Flat Number: ____
Number & Street: ____
Town: _______________ County: _______________ Postcode: ______________

On-line Services

21. **Patient Facing Services** -This is an on-line service that allows you to book appointments, order repeat prescriptions, view your medical records and also update your details, if you would like to register for this please ask Reception for an application.

22. If required are you happy for us to contact you via SMS message or email?
Yes ☐ No ☐

Next of Kin Details

23. Next of Kin's Relationship to you: ______________________________________
24. Title: ____ Family Name: _________________ Given Name: _________________
Telephone: _________________

25. If required in an emergency situation do you give Ridgmount Practice the permission to discuss your medical records with the above person?
26. Yes ☐ No ☐

Place of Birth Details

27. Country of Birth: ____________________ **25.** Place of Birth: ___________________

Previous GP Details in UK

28. Previous GP's Name/Surgery Name: _____________________________________
Previous GP's Address: ____

International Students (Questions 28-29)

29. Date you arrived in the UK for the first time : dd__/mm__ /yyyy____
30. Did you register with a GP the first time you came to the UK? Yes ☐ No ☐

Course Details

31. Please indicate if you are: Undergraduate ☐ Postgraduate ☐ Affiliate ☐
32. Course Start Date: ___/_____/_____ **31.** Course End Date: ____/_____/______
32. Name of Course: __________________ **33.** Department: ___________________

Lifestyle

34. Your current Smoking status is: **a)** Never Smoked ☐ **b)** Ex-Smoker ☐
____ Amount per day. Age you started smoking ____
c) Cigarette Smoker _____ per day **c1)** Age you started smoking________
d) Other ☐ please state _______________

35. Height: ______cm	**36.** Weight: ______Kg	**37.** How many units of alcohol do you drink per week? ____ *1 Unit = ½ pint of beer/1 medium glass of wine/ 1 spirit measure e.g. vodka/Rum/Gin*

Alcohol Consumption Questionnaire

Questions	**Scoring System**					**Your score**
	0	**1**	**2**	**3**	**4**	
1. 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	=
2. 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+	=
3. 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	=
If you scored 5 or more please answer Questions 4 to 10. Total =						
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	=
5. How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	=
6. How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	=
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	=
8. How often during the last	Never	Less	Monthly	Weekly	Daily	=

year have you been unable to remember what happened the night before because you had been drinking?		than monthly			or almost daily	
9. Have you or somebody else been injured as a result of your drinking?	No		Yes but not in the last year		Yes, during the last year	=
10.Has a relative or friend, doctor or health worker been concerned about your drinking or suggested that you cut down?	No		Yes but not in the last year		Yes, during the last year	=
					TOTAL	=

38. Are you A Carer or do you have a Carer?
I am A Carer I Have a Carer Not applicable

39. Details of Carer/Person you Care for: Relationship: ____________________________
Title: _____Family Name:____________________Given Name: __________________
Telephone: _________________________

Gynaecological Examination to detect pre-cancer cells/Smear Test/Pap Smear/ 子宫颈抹片检查,可以早期侦测子宫颈癌

40. Date of last Cervical Smear? (PAP Test) ________/__________/__________

41. Where was it taken? **GP Surgery** ☐ (GMS another practice)
Other UK Clinic/Hospital ☐ (Not GMS) **Abroad** ☐ (Not GMS)

42. Cervical Smear Result:Negative/Normal ☐ Abnormal ☐ Details ________________

43. Please complete dates of Immunisations

Immunisation	Date	Immunisation	Date
a. Meningitis ACWY	____/____/_________	c. 1st MMR	____/____/_________
b. Meningitis C	____/____/_________	d. 2nd MMR	____/____/_________

Please read the following important information
We recommend HIV testing for all new patients if you do not wish to have this please inform the Doctor or Nurse at your consultation

Personal Medical History (Please tick if you have had/have any of the following and give more details where possible)

Heart Attack		Heart Disease		Heart Failure		Angina (Heart condition)	
Stroke/TIAs		Hypertension (on		Hypothyroidism		Depression (on	

		medication)		(Underactive)		medication)	
Learning Disabilities		Diabetes Type 1		Diabetes Type 2		Epilepsy	
COPD		Asthma Requiring Inhalers		Chronic Kidney Disease		Schizophrenia	
Bipolar Disorder		Other Psychoses		Cancer		Dementia	

44. Please give details of current or past medical problems other than previously specified:

45. Please give details of any hospital treatment or operations?

46. Please state any relevant medical **Family History**:
Mother: ____________________ Father: ________________________
Brother: _____________________ Sister: ________________________
Other (State relationship): ______________________________________

47. Please give details of **any medication** you take on a regular basis:

48. Allergies: Please give details of any allergies you have:

Summary Care Record (SCR) For more information go to www.nhscarerecords.nhs.uk/summary or take a leaflet from reception

49. Would you like a Summary Care Record? Yes ☐ No ☐
Please see information provided.

Care.data For more information please take a leaflet from Reception or go to www.nhs.uk/nhsengland/thenhs/records/healthrecords/pages/care-data.aspx

50. Are you happy for your anonymised data to be shared for secondary use?
Yes ☐ No ☐

51. Are you happy for your anonymized data to be shared with 3rd parties by HSCIC?
Yes ☐ No ☐

CIDR Camden Integrated Digital Record, is a local initiative to enable your care providers in Camden to view the relevant information when treating you and so give you the best possible care.

52. You are **automatically Opted In** to CIDR if you would like to **Opt Out** please ask Reception for the CIDR Opt out form.

53. Your Signature:______________________________Date: ______/______/_______