Registering at Crane Park Surgery

To register at Crane Park Surgery we will need you to provide the following:

Proof of ID

We require your passport. If you do not have a passport we will require your driving licence (with photo) or birth certificate.

Proof of Address

An official document e.g., utility bill or bank statement dated within the last 3 calendar months.

PLEASE NOTE: Our busiest times are before 9.30am and after 5.30pm so please avoid coming to register at these times.

The surgery is closed between 1pm and 2pm every day

Online Access

Once you are registered with the practice you can also enrol for our online patient access service which allows you to book appointments, order repeat prescriptions and view certain aspects of your patient record. Please ask at reception for a registration form. You will then be provided with a registration link to enable you to access the online website at www.patientaccess.com. You can also use the NHS app to link to online services and gain access to other features such as your Covid passport.

PLEASE NOTE

The surgery operates a zero-tolerance policy.

Violent or abusive behaviour towards staff will not be tolerated under any circumstances

Dr. VNP Sinha
MBBS MD DPath

Dr. Withya Rajakulendran
MBBS MRCGP

Crane Park Surgery

Whitton Corner

Percy Road, Whitton

Middlesex TW2 6JL

Tel: 020 3405 0820

NEW PATIENT QUESTIONNAIRE

NAME: DATE OF BIRTH:

ADDRESS:

TEL: HOME: WORK:

MOBILE: EMAIL:

GENDER: FEMALE: MALE: OTHER:

ARE YOU HAPPY TO RECEIVE COMMUNICATION BY TEXT MESSAGE YES/NO

ARE YOU HAPPY TO RECEIVE COMMUNICATION BY EMAIL YES/NO

ARE YOU HAPPY FOR YOUR MEDICATION AND ALLERGY RECORDS TO BE AVAILABLE TO OTHER AGENCIES: YES/NO

Country of origin: Occupation:

Please state your ethnicity:

What is your first language? Interpreter required? YES/NO

Number of children:

Are you a carer? YES/NO If yes, who do you care for?

Do you have a carer? YES/NO If yes, please provide details:

Do you have a social worker? If yes, please provide details:

PLEASE LIST ANY PRESCRIBED MEDICATIONS YOU ARE CURRENTLY TAKING. PLEASE ENSURE THAT YOU HAVE A SUFFICIENT QUANTITY OF YOUR MEDICATION AS YOU MAY NEED TO SEE ONE OF OUR GPs BEFORE GETTING A FURTHER SUPPLY AND AN APPOINTMENT MAY NOT BE AVAILABLE IMMEDIATELY.

MEDICATION NAME	DOSE	HOW OFTEN

PLEASE LIST ANY MEDICATIONS CAUSING ALLERGY OR ADVERSE REACTION

DO YOU HAVE A LOCAL NOMINATED PHARMACY? IF SO WHICH ONE?

GENERAL MEDICAL HISTORY

Please list any serious illnesses, operations or any condition for which you take medication including Diabetes, Cancer, Heart Disease, Asthma, High Blood Pressure, COPD, Mental Health issues. State year of diagnosis, if known.

Illness	Date, if known
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

SIGNICANT FAMILY HISTORY Please list any conditions below:
1.
2.
3.
4.
5.

SMOKING

Have you ever smoked YES/NO	If yes, date started Cigarettes/Cigars per day
Ex-smoker	How many years?

ALCOHOL

AUDIT-C Questionnaire

Patient Name ______________________________ Date of Visit _____________

1. How often do you have a drink containing alcohol?

- ☐ a. Never
- ☐ b. Monthly or less
- ☐ c. 2-4 times a month
- ☐ d. 2-3 times a week
- ☐ e. 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?

- ☐ a. 1 or 2
- ☐ b. 3 or 4
- ☐ c. 5 or 6
- ☐ d. 7 to 9
- ☐ e. 10 or more

3. How often do you have six or more drinks on one occasion?

- ☐ a. Never
- ☐ b. Less than monthly
- ☐ c. Monthly
- ☐ d. Weekly
- ☐ e. Daily or almost daily

Drinking more than 14 units of alcohol per week increases the risk of alcohol related illnesses.
1unit equals ½ pint of beer, ½ glass of wine or 1 spirit measure. Please state your weekly alcohol consumption in units.

EXERCISE

Do you take regular exercise? YES/NO

If YES, please state what form of exercise and how often.

FOR FEMALE PATIENTS ONLY

Have you had any children?	YES/NO	Please give details below
Child	Age:	Gender:
Child 1	Age:	Gender:
Child 2	Age:	Gender:
Child 3	Age:	Gender:
Child 4	Age:	Gender:
Child 5	Age:	Gender:
When was your last smear test?	Date:	
When was your last mammogram?	Date:	
Have you had a hysterectomy?	Date:	
Contraception	YES/NO	Method:

ADDITIONAL INFORMATION

Please use the space below to provide additional information that you feel may be important in managing your healthcare.