CLINIC REGISTRATION FORM TO BE COMPLETED BY PATIENT

75-76 Wimpole Street, W1G 9 RT

Clinic Director
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QUEENS CLINIC
THE LONDON GYNAECOLOGY CLINIC

Patients ID no:

First Name: _____ **Surname:** _____ **Date:** _____/_____/_____

Local Address: _____ **Phone:** _____

_____ **Mobile:** _____

Overseas Address : _____ **Overseas Phone: (_____)** _____

_____ **I prefer to be contacted by:**

Country of Origin: _____ **Phone** ☐ **Mobile** ☐ **Post** ☐ **Email** ☐

Email:_____ **I do not want to be sent unsecure emails** ☐

I do not wish to have any promotions sent via

Date of Birth: _____ **Age:** _____ **email, text, or post.** ☐

Gender: _____ **GP Name:** _____

Next of kin: _____ **Contact number:**_____ **GP Address:** _____

Relationship to you: _____ **GP Tel**: _____

Do you want Queens Clinic to correspond with your GP regarding your treatment?

Do you agree for Queens Clinic storing my data for medical reasons only?

Yes ☐ **No** ☐ **Yes** ☐ **No** ☐

Marital Status: Married ☐ Single ☐ Partner ☐ **Blood Group:**_____

Complaints: _____

_____

_____

_____

Past Medical History: _____

_____

_____

_____

Social History: _____

Operations: Yes ☐ **No** ☐ **Smoker: Yes** ☐ **No** ☐ **Alcohol: Yes** ☐ **No**

Allergies: _____

Current Medication: _____

_____

Obstetric History: _____

Family History: _____

_____

Menstrual History: Menarche: _____Cycle: _____LMP: _____

Sexual History: One Partner ☐ More than one partner ☐

History of Present Complaint: _____

_____

Systematic Enquiry: Date of last cervical cytology and result: _____

Patient Name:_____ **Patient ID Number:**_____

Headache: _____ **Dizziness:** _____ **Fainting:** _____

Blurred Vision: _____ **Tinnitus:** _____ **Bowel Habit:** _____

Nausea: _____ **Vomiting:** _____ **Indigestion:** _____

Dyspnoea: _____ **Chest Pain:** _____ **Cough:** _____

Flushing: _____ **Hot Sweats:** _____ **Dyspareunia:** _____

IMB, PCB, PMB: _____ **Vaginal discharge or irritation:** _____

Urinary Symptoms: Frequency, Dysuria, Haematuria, Nutria, Stress incontinence_____

Any Other Symptoms/ Problems: _____

INFERTILITY ☐ **PREGNANCY** ☐ **STD'S** ☐ **MENOPAUSE** ☐ **UNSPECIFIED** ☐ **BREAST** ☐ **GYNAECOLOGY** ☐

Do you wish to have Smear test?
Yes ☐ **No** ☐

Do you wish to have HPV test?
Yes ☐ **No** ☐

Do you wish to have STD's test?
Yes ☐ **No** ☐

Do you wish to have HIV test?
Yes ☐ **No** ☐

Do you wish to have Syphilis test?
Yes ☐ **No** ☐

Do you wish to have Hepatitis B, C test?
Yes ☐ **No** ☐

Do you wish to have Breast scan?
Yes ☐ **No** ☐

Do you wish to have Annual Screen with/without hormones?
Yes ☐ No ☐

Patient Vital Signs					
Date					
UBG – URO					
PRO					
PH					
BLD-SNG ERY-HB					
SG-DEN					
KET-CET					
BIL					
GLU					
BP					
PLS					
WT					
HT					
BMI					
TEMPRATURE					

Except in the case of an emergency, it is Queens Clinic policy to have a chaperone for every patient during an examination. Queens Clinic endeavour to see every patient at the booking time, but please be aware that there could be delays for up to 2 hours, for which we apologize in advance. Any Patients payments for deliveries and operations paid in advance are non refundable. Payments for procedures must be paid for in advance. I agree to the policy ☐

I do not wish to have a breast examination: ☐ I do not wish to have a transvaginal ultrasound ☐

I do not wish to have a pelvic examination ☐

Self Paid (Cash/ Credit/Debit Card) ☐ Embassy ☐ Insurance ☐

Please be aware of our card charges: £5 for Debit cards, +5% for credit card charges, and +7% for American express

Medical Insurer's Name: _____ Other (please specify)_____

Group Number: _____ **Membership No./ Insurer Policy:** _____

Scheme name/ Scale of Cover: _____

Pre-Auth/ Claim Number: _____

Policy Holder's Name: _____

Should you need more information, please do not hesitate to ask for it.

Patient Signature:_____ Date:_____

Chaperone :_____ Secretary:_____

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