**New Patient Questionnaire**

**Dear Patient,**

This set of questions has been designed to help us to get to know you and your medical problems. **Please fill in the entire form or there could be delays in your registration.** All the information gathered from these questions will be handled confidentially. Your named accountable GP will be **Dr Nandanavanam**.

**Surname**: ……………………………………….……… **Forenames**: ………………………………..………………………………. **Sex: M/F**

**Address**: …………………………………………………………………………..…………………………………………………………..……………

**Post Code**: …………………………… **Tel No**: ……………………………………… **Mobile No:** …………………………………………………..

**Email address:** …………..……………………………………………………………………………

Your Preferred Method of Contact (please circle): SMS / Telephone / Letter / Email

*This is how the surgery will contact you unless in an emergency*

**DOB**: .…../………/……. **Country of Birth**: ……………………………………………….……… **Marital Status**: ……..………….

**Children**: Male ………… Female ………..…… **Occupation** (past & present) …………………..………………………….

**Place of Birth**……………………………………………………….

**Have you been a member of the Armed Forces** ………………………………………………………………………………………………

**Next of Kin / Emergency Contact Name:** ……………………………………………… **Relationship to You**: ………………………….……………

**Tel No:** …………………………………………………………… **Address:** ………………………………………………………………………………………………

**ETHNICITY**

|  |  |  |  |
| --- | --- | --- | --- |
| White British  | Indian  | Black Caribbean | Any Mixed Background |
| Other White British | Pakistani | Black African | Other Ethnic Group |
| White Irish | Chinese | Black British | Other |
| White European  | Other Asian | Other Black | Patient Declined |
| **Main Spoken Language \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Interpreter Needed: YES 🞏 NO 🞏**  |

**HEIGHT & WEIGHT**

Do you know your Height …………………………..……… & Weight ………………………………………………

At this surgery we offer weight management advice. Would you in interested in speaking to our clinician for weight management advice? **YES / NO**

**PRESENT ILLNESSES/TREATMENTS**

Please list all illnesses you are receiving hospital treatment for:

*
*
*
*

**PRESENT MEDICINES (Prescribed)**

Please provide a printed list from your previous practice of any medicines or tablets you are taking at present and the illness for which you are taking them. If you require repeat medication, please provide us with either the last computer tear-off slip, showing the medication prescribed or the original containers showing the relevant information.

**If you do not have a printed list, please give details of any medication you take (prescribed or otherwise):**

**MEDICATION**

Name of drug: …………………………………………………………………………………………………………….

Dosage: ……………………………………………………………………………………………………………………..

Name of drug: …………………………………………………………………………………………………………….

Dosage: ……………………………………………………………………………………………………………………..

Name of drug: ………………………………………….……………………………………………………………….…

Dosage: ……………………………………………………………………………………………………………………..

**ALLERGIES & DISABILITIES:**

Are you allergic or sensitive to any medicines, food, animals, etc.? [ ]  Yes [ ]  No

If yes please put what allergy you have:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have a disability?** [ ]  Yes [ ]  No If yes please state \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you class your disability as  **Slight** [ ]  **Moderate** [ ]  **Severe** [ ]

(*Please note the answer to the above may have an impact on any future life insurance policy or private health insurance premiums*)

 Do you have any communication difficulties that may require any additional assistance?

(for example: sensory loss, language barrier etc.)

**If yes, please write difficulty here:**

**CARERS**

Do you need / have anyone who looks after you or your daily needs? **Yes / No**

If “Yes”, would you like them to deal with your health affairs here? **Yes / No**

(the receptionist can help with these arrangements)

What is the name and contact details of your carer? ……………………………….…………………………………………………..

Do you care for anyone else? **Yes / No**

If “Yes”, ask the receptionist about Carers support

What is the name of the person being cared for: ……………………………………………………..

**THIRD PARTY CONSENT:**

At this surgery we understand that communication can be difficult for some patients, or that there may be occasions where you wish for someone else to call us and obtain information from your records on your behalf such as a carer or next of kin. Due to GDPR regulations we are not permitted to give **any** information to **anyone** other than the patient unless we have written consent from the patient beforehand. If you would like to consent or get more information about Third Party Information Sharing with a Specified Person please ask at reception.

**SMOKING:**

Have you ever smoked? **YES 🞎 / NO 🞎**

Are you a current smoker? **YES 🞎 / NO 🞎**

**If YES:** Would you like to stop smoking?**: YES 🞎 / NO 🞎**

Cigarettes per day …………. Cigars per day ..……….. Ounces of tobacco per day …………...

Are you at risk of exposure to tobacco smoke? **YES 🞎 / NO 🞎**

**DRUG USE:**

Have you ever used illicit drugs? **YES 🞎 / NO 🞎**

**If Yes**, are you currently using any illicit substances? **YES 🞎 / NO 🞎**

**If Yes,** please state what type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If Yes,** do you wish to receive help in order to stop? **YES 🞎 / NO 🞎**

**MEMORY:**

Have you ever had concerns about your memory? **YES 🞎 / NO 🞎**

**FEMALE PATIENTS ONLY**

Date of most recent cervical smear: …………..…………….Where was this done: ………………………………………….……………

Results of most recent smear: ………………………………………………………………………

**Please Note: If you do not wish to have a cervical smear please ask to sign a disclaimer which will deduct you from our recall list for 5 years**

Do you use contraceptives (please tick):

* The Pill 🞏
* Intra-Uterine Coil 🞏 (if ‘yes’ please provide date due for removal: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
* Diaphragm🞏
* Sheath 🞏
* Other Methods 🞏
* Sterilized/partner had vasectomy 🞏
* Not applicable 🞏

**Patient Data Consent Form**

Please read the following carefully as it will give you information about how we protect, use and share, your electronic and paper-based health record.

1. **How we protect your information within the Legislative Framework**

The purpose for which we hold and process both personal and medical data is to assist the Practice in the provision and administration of patient care. As guardian of this information, we endeavour to follow a code of conduct which encompasses ‘The Access to Medical Records Act 1990’, ‘The Freedom of Information Act 2000’, ‘The Data Protection Act 1998’, ‘The Common Law Duty of Confidentiality’ and adhere to the NHS Code of Practice when sharing information between health professionals in support of patient care. We will **not** share or disclose your information with other 3rd parties (outside of the said purpose), unless we have your signed consent to do so.

We ask that you consent to the information that is recorded about you, being made available to other NHS care services that care for you now and in the future for e.g. Secondary Care Services, District Nursing Services, Community Services etc.

**Please tick box to note consent:**

1. **Summary Care Record – your emergency care summary**

The NHS introduced the Summary Care Record, to ensure that those caring for you in an emergency situation have enough information to treat you safely. The Summary Record contains information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had.

**Please tick box to note consent**

Further information can be accessed from the follow links:

[www.nhs**carerecords**.nhs.uk](http://www.nhscarerecords.nhs.uk)

[www.legislation.gov.uk](http://www.legislation.gov.uk)

**Please let us know if you do not want a Summary Care Record or to share your information with other NHS Services and we will provide you with an opt-out form.**

1. **Messages to patient’s via Text (SMS) and Email**

The practice offers SMS Text messaging service to your mobile phone. We use this service in several ways:

* To remind patients about their appointments
* To ask them to contact the practice
* To inform them on current health screening opportunities and in some cases about test results etc

(None of these messages will contain your name)

Due to the personal content of these messages, it is very important that you keep the Practice informed of any changes to your mobile phone number or email address.

(Please note that the NHS mail messaging service utilises the public telephone network and as such full security is not guaranteed)

**Please tick box to note consent**

1. **Medical Photography Consent**

To help practice staff, there may be occasions when a clinician requires a medical image to review and compare particular skin lesions. We therefore ask that you give consent for medical imaging for medical purposes only.

**Please tick box to note consent**

**Patient’s Signature**

I ………………………………………………………………… (Patients Name)

Give my consent for IH Medical to hold and process my personal data as noted above in the Patient Data Consent Form

**Signature**………………………………………………………………………. **Date**……………………………………….

***PLEASE PROVIDE ID TO REGISTER FOR THIS SERVICE***

**Patient Online: Registration form**

**Access to GP online services – Over 18’s Only**

|  |  |
| --- | --- |
| Surname |  |
| First Name |  |
| Date of Birth |  |
| Address |  |
| Postcode |  |
| Email Address |  |
| Telephone Number |  | Mobile Number |  |

 I wish to have access to the following online services (tick all that apply):

|  |  |  |
| --- | --- | --- |
| 1. | Booking appointments |  |
| 2. | Requesting repeat prescriptions |  |
| 3. | Accessing my medical record |  |

 **Application for online access to my medical record**

 I wish to access my medical record online and understand and agree with each statement (please tick)

|  |  |  |
| --- | --- | --- |
| 1. | I have read and understand the information leaflet provided by the practice |  |
| 2. | I will be responsible for the security of the information I see or download |  |
| 3. | If I choose to share my information with anyone else, this is at my own risk |  |
| 4. | I will contact the practice as soon as possible if I suspect that my account has been accessed by someone else without my agreement |  |
| 5. | If I see information in my record that is not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Signature |  | Date |  |

For Practice Use Only:

|  |  |  |
| --- | --- | --- |
| Patient NHS Number: | Identity Verified by (initials): | Date: / / |
| Method of Verification:  Vouching 🞏 Vouching with information from record 🞏 Photo ID 🞏 |
| Authorised by (initials):  | Date Account Created: / /  | Date Passphrase Sent: / / |
| Level of record access enabled:All 🞏 Prospective🞏 Retrospective 🞏 Detailed Coded Record 🞏 Limited Parts 🞏 | Reason why:  |