**Patient registration and health questionnaire**

***Please complete all pages in full using block capitals***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Contact Details** | | | | | | |
| **NHS Number** |  | | *If you have had a previous GP then you will find this on letters / prescriptions or at* [*www.nhs.uk/find-nhs-number*](http://www.nhs.uk/find-nhs-number) | | | |
| **Name** |  | | **Gender** | |  | |
| **Previous Surname (if applicable)** |  | | | | | |
| **Address** |  | **Date of birth** | | |  | |
| **Home telephone** | | |  | |
| **Work telephone** | | |  | |
| **Previous Address** |  | | | | | |
| **Mobile telephone** | *I consent to be contacted by SMS on this number:  YES  NO* | | | | | |
| **Email** | *I consent to be contacted by email on this address:  YES  NO* | | | | | |
| **Next of kin** | Name: | Tel: | | | Relationship: | |
| **Have you been registered in the NHS before?** | | | | Yes | | No |
| **If no please state the date you entered the UK:** | | | |  | | |

*It is your responsibility to keep us updated with any changes to your telephone number, email address and postal address. We may contact you with appointment details, test results, health campaigns or Patient Participation Group details. If you* ***do not*** *consent to being contacted by SMS or Email, please tick here:*

*SMS  Email*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Other details** | | | | | |
| **Previous GP** | Name: | | | Address: | |
| **Country of birth** |  | | | | |
| **Ethnicity** | White (UK)  White (Irish)  White (Other) | Black Caribbean  Black African  Black Other | | Bangladeshi  Indian  Pakistani | Chinese  Other |
| **Religion** | C of E  Catholic  Other Christian | Buddhist  Hindu  Muslin | | Sikh  Jewish  Jehovah’s Witness | No religion  Other |
| **Housing** | Own House  Rented House  Shared House | Nursing Home  Residential Home  Sheltered Home | | Homeless  Housebound | Asylum Seeker  Refugee |
| **Employment** | Employment  Self-employed | Student  Unemployed | | House Husband  House Wife | Carer  Retired |
| **Overseas Visitor** | Yes | European Health Insurance Card Held (please bring details with you) | | | |
| **Armed Forces** | Military Veteran | | Family Member | | |

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| --- | --- | --- | --- |
| **Communication Needs** | | | |
| **Language** | What is your main spoken language? | |  |
| Do you need an interpreter? | | Yes  No |
| **Communication** | Do you have any communication needs? | | Yes  No  *(if yes please specify below)* |
| Hearing Aid  Lip reading | Large Print  Braille | British Sign Language  Makaton Sign Language  Guide dog |

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| **Carer Details** | | | | | | |
| **Are you a Carer?** | Yes – Informal / Unpaid Carer | | Yes – Occupational / Paid Carer | | | No |
| **Do you have a Carer?** | Yes | Name: | | Tel: | Relationship: | |

*Only add carer’s details if they give their consent to have these details stored on your medical record.*

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| **Medical History** | | | |
| Have you suffered from any of the following conditions? | | | |
| Asthma  COPD  Epilepsy | Heart Disease  Heart Failure  High blood pressure | Diabetes  Kidney Disease  Liver Disease | Depression  Thyroid  Cancer |
| Any other conditions, operations or hospital admission details:  If you are currently under the care of a hospital or consultant outside our area, please tell us here: | | | |

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| **Family History** | | | |
| *Please record any significant family history of close relatives with medical problems and confirm which relative e.g. mother, father, brother, sister, grandparent* | | | |
| Asthma  COPD  Epilepsy | Heart Disease  Stroke  Blood Pressure | Diabetes  Kidney Disease  Liver Disease | Depression  Thyroid  Cancer |
| Other:  Family History: | | | |

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| **Allergies** |
| Please record any allergies or sensitivities below: |

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| **Current Medication** |
| *Please check and include as much information about your current medication below.*  *Please give us your previous repeat medication list if possible and a medication review appointment may be needed.* |

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| ***Your lifestyle*** | | | | | | |
| **Alcohol** | | | | | | |
| Please answer the following questions which are validated as screening tools for alcohol use: | | | | | | |
| AUDIT-C Questions | Scoring System | | | | | Your Score |
| 0 | 1 | 2 | 3 | 4 |
| 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 |  |
| 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+ |  |
| 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 |  |
| *A score of less than 5 indicates lower risk drinking* | | | | | TOTAL: |  |

*Scores of 5 or more requires the following 7 questions to be completed:*

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| --- | --- | --- | --- | --- | --- | --- |
| *AUDIT Questions*  *(after completing 3 Audit-C questions above)* | *Scoring System* | | | | | *Your Score* |
| *0* | *1* | *2* | *3* | *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 |  |
| 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 |  |
| 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 |  |
| 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 |  |
| How often during the last year have you been unable to remember what happened the night before because you had been drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| Have you or someone else been injured as a result of your drinking? | No |  | Yes but not in the last year |  | Yes, during the last year |  |
| Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down? | No |  | Yes, but not in the last year |  | Yes, during last year |  |
|  | | | | | TOTAL: |  |

[](http://www.citsu.ie/alcohol-and-drug-awareness)

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| --- | --- | --- | --- | --- |
| **Your Lifestyle – Continued** | | | | |
| **Smoking** | | | | |
| Do you smoke | Never smoked | Ex-smoker | | Yes |
| Do you use an e-Cigarette? | No | Ex-User | | Yes |
| How many cigarettes did/do you smoke a day? | Less than one | 1-9 | | 10-19 |
| 20-39 | 40+ | |  |
| Would you like help to quit smoking? | Yes | | No | |
| *For further information, please see:* [*www.nhs.uk/smokefree*](http://www.nhs.uk/smokefree) | | | |

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| **Height and Weight** | |
| Height |  |
| Weight |  |
| Waist Circumference |  |

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| --- | --- | --- |
| **Women Only** | | |
| Do you need any contraception? | Yes | No If needed, please book appointment |
| Do you have a coil or implant insitu? | Yes | No Date inserted: |
| Are you currently pregnant or think you may be? | Yes | No Expected due date: |

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| **Students Only** | | | |
| *Students are at risk if certain infections including mumps, meningitis and sexually transmitted infections, as well as mental health issues including stress, anxiety and depression. Please see* [*www.nhs.uk/livewell/studenthealth*](http://www.nhs.uk/livewell/studenthealth) | | | |
| I am less than 24 years old and have had two doses of the MMR Vaccination | Yes | No | Unsure |
| I am less than 24 years old and have has a Meningitis C Vaccination | Yes | No | Unsure |

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| **Prescriptions**  (It is important for those patients who are eligible to have their prescriptions dispensed by the surgery to use this service in order for us to keep this service within the surgery) | | | |
| Do you live within 1 mile of a chemist / pharmacy?  (*if so we are unable to dispense your medication)* | | Yes | No |
| If no, would you like your prescriptions dispensed from our dispensary? | | Yes | No |
| If you would like to collect your prescriptions from a chemist / pharmacy, please state the name and address of where you would like your prescription to be electronically sent to. | | | |
| Name: | | | |
| Address: | | | |
| Do you have any repeat medications? | | Yes | No |
| If yes please list: | | | |
|  | | | |
| When you are next due to collect your prescriptions? |  | | |

***PLEASE NOTE:*** *Please request your prescription a week before you are due to start taking them to allow the dispensary time to process your request. You can via the NHS app, online, email or post. (WE DO NOT ACCEPT TELEPHONE REQUESTS)*

*Dispensary opening hours are:*

|  |  |
| --- | --- |
| *Monday* | *09:00-11:30am & 3:30-5:30pm* |
| *Tuesday* | *09:00-11:30am & 3:30-5:30pm* |
| *Wednesday* | *09:00-11:30am & 2:00-3:30pm* |
| *Thursday* | *09:00-11:30am & 3:30-6:00pm* |
| *Friday* | *09:00-11:30am & 3:30-5:30pm* |

*Dispensary will take telephone calls for medication queries between:*

*Mon – Fri 1:00pm – 2:00pm*

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| **Patient** **Participation Group** | | |
| Would you like to be involved in our Patient Participation Group? | Yes | No |

*We are committed to improving the services we provide. The Patient Participation Group is a mechanism for us to gain valuable feedback from our patients about their experiences, views and ideas for improving our services. Our PPG meet 4 time a year.*

|  |  |
| --- | --- |
| **Blood and Organ Donation** | |
| Blood donation | I am already a blood doner  I wish to be a blood doner  I do not wish to be a blood doner |
| Organ donation | You will automatically be considered that you agree to become an organ doner when you die unless you are under 18, have opted out or are in an excluded group.  For further information, please see: [www.organdonation.nhs.uk](http://www.organdonation.nhs.uk) |

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| **Signatures** | |
| Signature | I confirm that the information I have provided is true to the best of my knowledge.  Signed on behalf of the patient |
| Name |  |
| Date |  |

Checklist:

Please ensure the following are done and provided so that your registration can be completed successfully.

Completed & signed above form

Completed & signed GMS1 form

Photo proof of ID e.g. Passport, photo driving license or photo ID card

Proof of address e.g. bank statement, utility bill or council tax from within the last 3 months

**PRACTICE USE ONLY:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Appointment | Required | Not required |  |  |
| Photo ID | Passport | Driving License | Identity Card | Other |
| Proof of Address | Utility Bill | Council Tax | Bank Statement | Other |

**Sharing Your Health Record**

**What is your health record?**

Your health record contains all the clinical information about the care you receive. When you need medical assistance it is essential that clinicians can securely access your health record. This allows them to have the necessary information about your medical background to help them identify the best way to help you. This information may include your medical history, medications and allergies.

**Why is sharing important?**

Health records about you can be held in various places, including your GP practice and any hospital where you have had treatment. Sharing your health record will ensure you receive the best possible care and treatment wherever you are and whenever you need it. Choosing not to share your health record could have an impact on the future care and treatment you receive. Below are some examples of how sharing your health record can benefit you:

* Sharing your contact details This will ensure you receive any medical appointments without delay
* Sharing your medical history This will ensure emergency services accurately assess you if needed
* Sharing your medication list This will ensure that you receive the most appropriate medication
* Sharing your allergies This will prevent you being given something to which you are allergic
* Sharing your test results This will prevent further unnecessary tests being required

**Is my health record secure?**

Yes. There are safeguards in place to make sure only organisations you have authorised to view your records can do so. You can also request information regarding who has accessed your information from both within and outside of your surgery.

**Can I decide who I share my health record with?**

Yes. You decide who has access to your health record. For your health record to be shared between organisations that provide care to you, your consent must be gained.

**Can I change my mind?**

Yes. You can change your mind at any time about sharing your health record, please just let us know.

**Can someone else consent on my behalf?**

If you do not have capacity to consent and have a Lasting Power of Attorney, they may consent on your behalf. If you do not have a Lasting Power of Attorney, then a decision in best interests can be made by those caring for you.

**What about parental responsibility?**

If you have parental responsibility and your child is not able to make an informed decision for themselves, then you can make a decision about information sharing on behalf of your child. If your child is competent then this must be their decision.

**What is your Summary Care Record?**

Your Summary Care Record contains basic information including your contact details, NHS number, medications and allergies. This can be viewed by GP practices, Hospitals and the Emergency Services. If you do not want a Summary Care Record, please ask your GP practice for the appropriate opt out form. With your consent, additional information can be added to create an Enhanced Summary Care Record. This could include your care plans which will help ensure that you receive the appropriate care in the future.

**How is my personal information protected?**

<Organisation Details> will always protect your personal information. For further information about this, please see our Privacy Notice on our website or please speak to a member of our team

For further information about your health records, please see: [www.nhs.uk/NHSEngland/thenhs/records](http://www.nhs.uk/NHSEngland/thenhs/records)

For further information about how the NHS uses your data for research & planning and to opt-out, please see: [www.nhs.uk/your-nhs-data-matters](http://www.nhs.uk/your-nhs-data-matters)

|  |
| --- |
| **Sharing Your Health Record** |
| **Your Health Record** |
| Do you consent to your GP Practice sharing your health record with other organisations who care for you?  Yes (recommended option)  No, never |
| Do you consent to your GP Practice viewing your health record from other organisations that care for you?  Yes (recommended option)  No |

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| **Your Summary Care Record (SCR)** |
| Do you consent to having an Enhanced Summary Care Record with Additional Information?  Yes (recommended option)  No |

|  |  |
| --- | --- |
| **Signature** | |
| Signature | Signed on behalf of patient |
| Name |  |
| Date |  |

**Access to GP Online Services**

**Important Information – Please read before completing form below**

If you wish to, you can now use the internet (via computer or mobile app) to book appointments with a GP, request repeat prescriptions for any medications you take regularly and look at your medical record online. You can also still use the telephone or call in to the surgery for any of these services as well. It’s your choice.

It will be your responsibility to keep your login details and password safe and secure. If you know or suspect that your record has been accessed by someone that you have not agreed should see it, then you should change your password immediately. If you are unable to do this for some reason, we recommend that you contact the practice so that they can remove online access until you are able to reset your password.

If you print out any information from your record, it is also your responsibility to keep this secure. If you are at all worried about keeping printed copies safe, we recommend that you do not make copies at all.

During the working day it is sometimes necessary for practice staff to input into your record, for example, to attach a document that has been received, or update your information. Therefore you will notice admin/reception staff names alongside some of your medical information – this is quite normal.

The definition of a full medical record is all the information that is held in a patient’s record; this includes letters, documents, and any free text which has been added by practice staff, usually the GP. The coded record is all the information that is in the record in coded form, such as diagnoses, signs and symptoms (such as coughing, headache etc.) but excludes letters, documents and free text.

Before you apply for online access to your record, there are some other things to consider. Although the chances of any of these things happening are very small, you will be asked that you have read and understood the following before you are given login details.

|  |
| --- |
| **Forgotten history**  There may be something you have forgotten about in your record that you might find upsetting. |
| **Abnormal results or bad news**  If your GP has given you access to test results or letters, you may see something that you find upsetting to you. This may occur before you have spoken to your doctor or while the surgery is closed and you cannot contact them. |
| **Choosing to share your information with someone**  It’s up to you whether or not you share your information with others – perhaps family members or carers. It’s your choice, but also your responsibility to keep the information safe and secure. |
| **Coercion**  If you think you may be pressured into revealing details from your patient record to someone else against your will, it is best that you do not register for access at this time. |
| **Misunderstood information**  Your medical record is designed to be used by clinical professionals to ensure that you receive the best possible care. Some of the information within your medical record may be highly technical, written by specialists and not easily understood. If you require further clarification, please contact the surgery for a clearer explanation. |
| **Information about someone else**  If you spot something in the record that is not about you or notice any other errors, please log out of the system immediately and contact the practice as soon as possible. |

For further information, please see:

[www.nhs.uk/NHSEngland/AboutNHSservices/doctors/Pages/gp-online-services.aspx](http://www.nhs.uk/NHSEngland/AboutNHSservices/doctors/Pages/gp-online-services.aspx)

|  |  |
| --- | --- |
| **Online Access to your Health Record** | |
| Name: |  |
| NHS Number: |  |
| Date of Birth: |  |
| Address: |  |
| Telephone: |  |
| Email Address: |  |

|  |
| --- |
| **I wish to have online access to:** Please tick all that apply |
| Book appointments |
| Request Medication |
| View my medical record (subject to policy) |
| View my Summary Care Record |
| Complete Questionnaires |

|  |
| --- |
| **I wish to access my medical record & understand & agree with each statement** (please tick all that apply) |
| I have read and understood the ‘important information’ section below |
| I will be responsible for the security of the information that I see or download |
| If I choose to share my information with anyone else, this is at my own risk |
| I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement |
| 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** | |
| Signature |  |
| Name |  |
| Date |  |

**BERE REGIS SURGERY - DRUM**

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| --- | --- | --- | --- | --- | --- | --- |
| **Patient Name** |  | | | | | |
| Date of birth |  | Date: |  | Read Code | XaMhK |  |
| Reviewed by |  | Time: |  | Declined | XaMzC |  |

**Please help us to help you by completing this form. Please tick the appropriate column for each question:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | Require assistance | Comments |
| Can you read the labels and directions on your medication and understand them? |  |  |  |
| Do you know when to take your tablets? |  |  |  |
| Do you take your medication as it is prescribed? |  |  |  |
| Open and remove tablets from a blister pack |  |  |  |
| Open and close child resistant containers |  |  |  |
| Open and close regular containers |  |  |  |
| Pick up tablets from a table / counter |  |  |  |
| Swallow tablets |  |  |  |
| Apply eye, ear and external preparations |  |  |  |

**Please answer the following questions:-**

|  |  |
| --- | --- |
| Do you order your repeat medication items regularly? |  |
| Do you need to be reminded to order them? |  |
| Who collects your prescription? |  |
| Do you ever run out or forget to take your medication? |  |
| Does anybody help you take your medication? |  |
| Does all your medication run out at the same time? |  |
| Do you buy any over the counter medication? |  |
| Do you have problems accessing the Surgery or collecting your repeat prescription? |  |
| If we were to expand our delivery service in the future would you be interested? |  |
| Do you have any unwanted or waste medicines? |  |
| Do you have any medication that should no longer be on your repeat slip? | |
| When did you last see your GP or Practice Nurse to discuss your repeat medication? | |
| Any Comments/Ideas/Queries for the Dispensary Team that you may have: | |