NEW PATIENT QUESTIONNAIRE

Please complete as many questions as you can about yourself. The information provided will help the practice to provide better medical care for you and your family.

PERSONAL DETAILS:

Mr/Mrs/Miss/Ms/Other (please specify): .....

First Name: ..... Surname: .....

DOB: ..... NHS No: .....

Address: .....

.....

..... Postcode: .....

Tel No:..... Mobile No: .....

Email Address: .....

I CONSENT to receiving appointment confirmations and cancellations via text and will update the surgery of any changes to my mobile number:

Signature: ..... Date: .....

I DO NOT CONSENT to receiving appointment confirmations and cancellations via text:

Signature: ..... Date: .....

PATIENT ONLINE SERVICES

I would like to sign up to **SYSTMONLINE**, the practice online system for booking appointments, ordering repeat medication and viewing my medical record. *Password access and the password must be given to the patient only with proof of identity. Reception will generate the password (please speak with reception to set this up)

PLEASE CIRCLE: Yes / No

Washington House Surgery: 77 Halse Road, Brackley NN13 6EQ
Brackley Health Centre: 68 Halse Road, Brackley NN13 6EJ
Tel: 01280 702436
e-mail: reception.k83049@nhs.net

PLEASE COMPLETE ALL QUESTIONS BELOW

1. Are you a military veteran? Yes / No
2. Are you a member of a Military family? Yes / No
3. Occupation:.....
4. Do you have any disabilities? .....
5. Do you have any special requirements e.g. Hearing aid/wheelchair access/partially sighted?

   .....
6. Do you care for a relative or friend?: Yes / No
7. Do you have a carer?: Yes / No

   Carer's Name & Contact Details: .....
8. Next of Kin (Name/Relation/Contact Number): .....

NHS YOUR DATA MATTERS

If you do not want your confidential patient information to be used beyond your individual care please go to: www.nhs.uk/your-nhs-data-matters to learn more and manage your choice online. Alternatively you can call the NHS Digital Contact Centre on 0300 303 5678 between 9am to 5pm Monday to Friday (excluding bank holidays).

You must have an email address or phone number registered with an NHS service to continue online. You will need:

- your NHS number
- to have access to your email or mobile phone

PAST MEDICAL HISTORY

If you have been diagnosed with any of the following medical conditions, please detail the year of diagnosis.

Asthma:		Hypertension:	
Chronic Heart Disease:		Hypothyroidism:	
Chronic Kidney Disease:		Mental Health:	
COPD:		Pregnancy:	
Dementia:		Rheumatoid Arthritis:	
Diabetes (if so type):		Stroke/TIA:	
Epilepsy:			
Other illness / or operations:			

LIFESTYLE

SMOKING:

Are you:	
A smoker (if so, how many per day)	
Ex-smoker (when did you stop smoking)	
Never smoked	
Do not wish to answer	

ALCOHOL:

Please score yourself accordingly:

	0	1	2	3	4	Your score
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/ almost daily	
					TOTAL	

DIET & FITNESS

How would you class your diet?

Healthy:	
Average:	
Unhealthy:	
Other (details):	

Do you take regular exercise?

Yes (details):	
No:	

FAMILY HISTORY

Have any close family members suffered from any of the following? Please include relation, approximate age at diagnosis and/or age of death if relevant:

CONDITION	RELATIONSHIP	AGE WHEN DIAGNOSED / DEATH
Asthma:		
Cancer (please state type):		
Chronic Heart Disease:		
Diabetes (if so type):		
Heart Condition:		
High Blood Pressure:		
High Cholesterol:		
Other relevant history:		

ETHNIC GROUP (Please tick):

British:		Irish:		Asian:	
African:		Caribbean:		Bangladeshi:	
Chinese:		Indian:		Pakistani:	
Other (please specify):				Do not wish to answer:	

FIRST LANGUAGE SPOKEN (Please tick):

English:		Other (please detail):	

DRUGS & TREATMENT

Which local pharmacy would you like to collect your future prescriptions from? (Please tick):

Lowick (Brackley):		Co-op (Middleton Cheney):	
Lark Rise (Brackley):		Sainsbury's (Banbury):	
Boots (Brackley):		Other:	

1. Do any medicines disagree with you? Yes / No

   If yes, please detail:.....

2. Do you have any allergies? Yes / No

   If yes, please detail:.....

3. Have you had a course of tetanus injections/tetanus boosters in the last 10 years? Yes / No

   If yes, please detail:.....

Milton Keynes and Northamptonshire

Recommended Consent Options for New patient Registration Forms

Consent for Summary Care Record

The Summary Care Record (SCR) is a snapshot of your GP medical record which holds details of medication, allergies and adverse reactions and with your permission the practice can add any additional information you request i.e. Angina diagnosis. This may also include information detailing any health issues which you and your GP considers important to your wellbeing.

The Summary Care Record (SCR) is used by other NHS organisations such as A&E and Out Of Hours, and these organisations can only access this information with your permission. There maybe circumstances where staff cannot ask you for example if you are unconscious, therefore healthcare staff may look at your record without asking you.

For more information please ask Reception for an information leaflet.

Summary Care Record Consent Options

Please tick ONE option only:	
I consent for medication, allergies and adverse reactions only	
I consent for medication, allergies and adverse reactions **AND** additional information	
I request for my clinical information to be withheld from the Summary Care Record (Opt out form attached)	

Summary Care Records

NHS

Your emergency care summary

CONFIDENTIAL

OPT-OUT FORM

Request for my clinical information to be withheld from the Summary Care Record

If you **DO NOT** want a Summary Care Record please fill out the form and send it to your GP practice

A. Please complete in BLOCK CAPITALS

Title ..... Surname / Family name .....

Forename(s) .....

Address .....

Postcode..... Phone No..... Date of birth .....

NHS Number (if known)..... Signature .....

B. If you are filling out this form on behalf of another person or a child, their GP practice will consider this request. Please ensure you fill out their details in section A and your details in section B

Your name ..... Your signature.....

Relationship to patient..... Date .....

What does it mean if I DO NOT have a Summary Care Record?

NHS healthcare staff caring for you may not be aware of your current medications, allergies you suffer from and any bad reactions to medicines you have had, in order to treat you safely in an emergency.

Your records will stay as they are now with information being shared by letter, email, fax or phone.

If you have any questions, or if you want to discuss your choices, please contact your GP practice.

FOR NHS USE ONLY

Actioned by practice: yes / no Date.....