New Patient Questionnaire

Dear Patient

This set of questions has been designed to help us to get to know you and your medical problems. All the information gathered from these questions will be handled confidentially, however, if you have concerns regarding any questions, then please leave them blank and speak to the Practice Nurse. We would appreciate you returning the completed forms to the surgery at your New Patient Health Check appointment.

REGISTRATION CONSULTATION: Date…… Time…….. With……..

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

Address: ……

Post Code: …… **Tel No**: ……

Mobile No: ……..

Email address: ……

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

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

Place of Birth…… **Religion** ……..

Have you been a member of the Armed Forces ……

Housing: ……..

Next of Kin: …… **Relationship**: ……

Tel No: …… **Address:** ……

If you would like to register for online services please ask at reception for an application form.

COMMUNICATION

We want to get better at communicating with our patients. We want to make sure you can read and understand the information we send you. If you find it hard to read our letters or if you need someone to support you at appointments, please let us know.

We want to know if you need information in braille, large print or easy read.

We want to know if you need a British Sign Language interpreter or advocate.

We want to know if we can support you to lip-read or use a hearing aid or communication tool.

Please tell the receptionist when you arrive for your NEW PATIENT HEALTH CHECK, or call the practice and speak to a receptionist.

ETHNICITY **Interpreter Needed: YES/NO** **If YES, language** ……

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	☐

HEIGHT & WEIGHT

Do you know your Height …… & Weight ……

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

Are you allergic or sensitive to any medicines, food, animals, etc.?

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**
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: ……..

MEDICAL HISTORY (YOURSELF OR YOUR FAMILY)

Do you or your family members have any of the following illnesses or conditions:-

CONDITION	YES OR NO	WHO HAS/HAD THE CONDITION & AT WHAT AGE
High Blood pressure		
Heart Attack		
Stroke		
Angina		
Asthma		
Eczema/psoriasis		
Any Hereditary Diseases i.e. Cystic Fibrosis, Huntington's etc.		
Diabetes		
Breast or Bowel Cancer		
Any other illness or condition		

SMOKING

Do you smoke **Yes / No** How old were you when you started ……

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

Have you stopped smoking Yes/No When did you stop ……

Would you like to stop smoking**: Yes NO / (Please ask for further details)**

EX-SMOKERS Date when you stopped smoking? ……..

EXERCISE

Do you take regular exercise? **Yes / No**

If yes, what sort of exercise? ……How many times per week……

ALCOHOL - Please score below

Questions	0	1	2	3	4	Your score
How often do you have a drink that contains alcohol	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4 + times per week	
How many alcoholic drinks do you have on a typical day when you are drinking	1 - 2	3- 4	5 - 6	7 - 8	10+	
How often do you have 6 or more standard drinks on one occasion	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**	

Never drink alcohol: Please tick box: ☐

Pharmacy Nomination for Prescription Collection

If you wish, you can nominate a local pharmacy to receive and dispense your prescriptions; these are the choices in our practice area:

Name of Pharmacy	**Please tick**
Rowlands Cardinal Gardens (next door to surgery)	
Other please specify:	

Dear Patient

You may be aware that from April 2015 all practices are required to provide all their patients with a named GP who will oversee your care that our surgery provides.
Your named GP will be ……. This does not prevent you from seeing any GP in the practice.
You do not need to take any further action, but if you have any questions, or wish to discuss this further with us, please contact the surgery.

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
Diaphragm
Sheath
Other Methods
Sterilized/partner had vasectomy
Not applicable

CHILDREN UNDER THE AGE OF 5 - only

Previous School/Nursery: ……..

New School/Nursery:……..

Previous GP/Health Visitor Details: ……..

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: ☐

2. **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
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.

3. **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 ☐

Patient's Signature

I …… (Patients Name)
Give my consent for Carmel Surgery to hold and process my personal data as noted above in the Patient Data Consent Form

Signature……. **Date**…….

DR A FUAT
DR E MOORE
DR C MARKWICK
DR A ROSS
DR L WILSON
DR G GEDDES

CARMEL MEDICAL PRACTICE
NUNNERY LANE
DARLINGTON
CO DURHAM
DL3 8SQ

Telephone: 01325 520794
Facsimile: (01325) 381834

ZERO TOLERENCE POLICY

The Practice takes it very serious if a member of staff, which includes Reception, Doctors and Nursing Team, is treated in an abusive or violent way.

The Practice supports the Government's **'Zero Tolerance'** campaign for Health Service Staff. This states that GP's and their staff have a right to care for others without fear of being attacked or abused.

To successfully provide these services a mutual respect between all the staff and patients' individual needs and circumstances. They would respectfully remind patients that very often staff could be confronted with a multitude of varying and sometimes difficult tasks and situations, all at the same time.

Out staff understand that patients who are unwell do not always act in a reasonable manner and will take this into consideration when trying to deal with a misunderstanding or complaint.

However, aggressive behaviour, be it violent or abusive, will not be tolerated and may result in you being removed from the Practice list and, in extreme cases, the police being contacted.

In order for the Practice to maintain good relations with their patients, the Practice would like to ask all its patients to read and take note of the occasional types of behaviour that would be found unacceptable:

- Using bad language or swearing at practice staff.
- Any physical violence towards any member of the Practice Team or other patients, such as pushing and shoving.
- Verbal abuse towards the staff in any form.
- Racial abuse and sexual harassment will not be tolerated within this Practice.
- Persistent or unrealistic demands that cause stress to staff will not be accepted. Requests will be met wherever possible and explanations given when they cannot.
- Causing damage or stealing from the Practice's premises, staff or other patients.
- Obtaining drugs and/or medical services fraudulently.
- Abuse on public facing websites including social media sites.

We ask you to treat your GP's and their staff courteously at all times.
Thank you for you co-operation.

Carmel Medical Practice

Patients Name: _____

Signature:_____ Date:_____

NHS Family doctor services registration

GMS1

Patient's details

Please complete in BLOCK CAPITALS and tick ☑ as appropriate

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname

Date of birth

First names

NHS No.

Previous surname/s

☐ Male ☐ Female

Town and country of birth

Home address

Postcode

Telephone number

Please help us trace your previous medical records by providing the following information

Your previous address in UK

Name of previous doctor while at that address

Address of previous doctor

If you are from abroad

Your first UK address where registered with a GP

If previously resident in UK, date of leaving

Date you first came to live in UK

If you are returning from the Armed Forces

Address before enlisting

Service or Personnel number

Enlistment date

If you are registering a child under 5

☐ I wish the child above to be registered with the doctor named overleaf for Child Health Surveillance

If you need your doctor to dispense medicines and appliances*

**Not all doctors are authorised to dispense medicines*

☐ I live more than 1 mile in a straight line from the nearest chemist

☐ I would have serious difficulty in getting them from a chemist

☐ Signature of Patient ☐ Signature on behalf of patient Date_____/_____/_____

NHS Organ Donor registration

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.

☐ Any of my organs and tissue or

☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

Signature confirming my agreement to organ/tissue donation Date _____/_____/_____

For more information, please ask at reception for an information leaflet or visit the website www.uktransplant.org.uk, or call 0300 123 23 23.

NHS Blood Donor registration

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.

Tick here if you have given blood in the last 3 years ☐

Signature confirming consent to inclusion on the NHS Blood Donor Register Date _____/_____/_____

For more information, please ask for the leaflet on joining the NHS Blood Donor Register

My preferred address for donation is: (only if different from above, e.g. your place of work)

Postcode:

HA use only Patient registered for ☐ GMS ☐ CHS ☐ Dispensing ☐ Rural Practice

NHS Family doctor services registration

GMS1

To be completed by the doctor

Doctors Name HA Code

☐ I have accepted this patient for general medical services ☐ For the provision of contraceptive services

☐ I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice

Doctors Name, *if different from above* HA Code

☐ I am on the HA CHS list and will provide Child Health Surveillance to this patient or

☐ I have accepted this patient on behalf of the doctor named below, who is a member of this practice and is on the HA CHS list and will provide Child Health Surveillance to this patient.

Doctors Name, *if different from above* HA Code

☐ I will dispense medicines/appliances to this patient subject to Health Authority's Approval

☐ I am claiming rural practice payment for this patient.
Distance in miles between my patient's home address and my main surgery is

I declare to the best of my belief this information is correct and I claim the appropriate payment as set out in the Statement of Fees and Allowances. An audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission.

Authorised Signature

Name Date _____/_____/_____

Practice Stamp

SUPPLEMENTARY QUESTIONS

PATIENT DECLARATION for all patients who are not ordinarily resident in the UK

Anybody in England can register with a GP practice and receive free medical care from that practice.

However, if you are not 'ordinarily resident' in the UK you may have to pay for NHS treatment outside of the GP practice. Being ordinarily resident broadly means living lawfully in the UK on a properly settled basis for the time being. In most cases, nationals of countries outside the European Economic Area must also have the status of 'indefinite leave to remain' in the UK.

Some services, such as diagnostic tests of suspected infectious diseases and any treatment of those diseases are free of charge to all people, while some groups who are not ordinarily resident here are exempt from all treatment charges.

More information on ordinary residence, exemptions and paying for NHS services can be found in the Visitor and Migrant patient leaflet, available from your GP practice.

You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment. Even if you have to pay for a service, you will always be provided with any immediately necessary or urgent treatment, regardless of advance payment.

The information you give on this form will be used to assist in identifying your chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitals) and NHS Digital, for the purposes of validation, invoicing and cost recovery. You may be contacted on behalf of the NHS to confirm any details you have provided.

Please tick one of the following boxes:

a) ☐ I understand that I may need to pay for NHS treatment outside of the GP practice

b) ☐ I understand I have a valid exemption from paying for NHS treatment outside of the GP practice. This includes for example, an EHIC, or payment of the Immigration Health Charge ("the Surcharge"), when accompanied by a valid visa. I can provide documents to support this when requested

c) ☐ I do not know my chargeable status

I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

A parent/guardian should complete the form on behalf of a child under 16.

Signed:		**Date:**	DD MM YY
Print name:		**Relationship to patient:**	
On behalf of:			

Complete this section if you live in another EEA country, or have moved to the UK to study or retire, or if you live in the UK but work in another EEA member state. Do not complete this section if you have an EHIC issued by the UK.

NON-UK EUROPEAN HEALTH INSURANCE CARD (EHIC), PROVISIONAL REPLACEMENT CERTIFICATE (PRC) DETAILS and S1 FORMS

Do you have a non-UK EHIC or PRC?	YES: ☐ NO: ☐	If yes, please enter details from your EHIC or PRC below:
	Country Code:	
	3: Name	
	4: Given Names	
	5: Date of Birth	DD MM YYYY
	6: Personal Identification Number	
	7: Identification number of the institution	
	8: Identification number of the card	
	9: Expiry Date	DD MM YYYY
PRC validity period (a) From:	DD MM YYYY	(b) To: DD MM YYYY

If you are visiting from another EEA country and do not hold a current EHIC (or Provisional Replacement Certificate (PRC)/S1, you may be billed for the cost of any treatment received outside of the GP practice, including at a hospital.

Please tick ☐ if you have an S1 (e.g. you are retiring to the UK or you have been posted here by your employer for work or you live in the UK but work in another EEA member state). **Please give your S1 form to the practice staff.**

How will your EHIC/PRC/S1 data be used? By using your EHIC or PRC for NHS treatment costs your EHIC or PRC data and GP appointment data will be shared with NHS secondary care (hospitals) and NHS Digital solely for the purposes of cost recovery. Your clinical data will not be shared in the cost recovery process.

Your EHIC, PRC or S1 information will be shared with The Department for Work and Pensions for the purpose of recovering your NHS costs from your home country.