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|  | *BIRCHILLS HEALTH CENTRE* |
|  | *23-37 Old Birchills* |
|  | *Walsall* |
|  | *West Midlands* |
| ***Dr Avtar Singh SURI*** | *WS2 8QH* |
| ***Dr Anuradha MUNIYAPPA*** | *Tel: (01922) 614896* |
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| **NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *To register with the Practice please complete this questionnaire as fully as possible. The information will help the doctor to make an initial assessment of your health which will help in your future treatment. Failure to disclose information may result in your registration being declined now or you may be removed from our list in the future.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | Forename(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | |
| Date of Birth (dd/mm/yyyy): \_\_\_\_ /\_\_\_\_ /\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | Marital status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | |
| Address: ­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| Email address (in capitals only): | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  | |  | | |  |  | |  |  | |  |  |  |  | |  |  |  |  |  |
|  | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | |
| Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | Weight (approx): \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| Have you been previously registered at this surgery? (Regardless of how long ago) | | | | | | | | | | | | | | | | | | | | | | | | | YES / NO / NOT SURE | | | | | |

**FAMILY HISTORY**

* Heart Problems \*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Epilepsy \*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* High Blood Pressure \*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Diabetes \*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Cancer \*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Asthma \*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Stroke \*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Hypothyroidism \*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \* Please specify family member
* Other (please specify condition e.g.- T.B etc):

**NAME OF OTHER FAMILY MEMBERS BEING REGISTERED?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Date of Birth** |  | **Name** | **Date of Birth** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**MEDICAL HISTORY**

Hospital admissions/Operations/Scans/X-rays \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Present Complaints/Problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Complaints/Problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Present Medication - Please give details of any medication which you take (prescribed or otherwise):

|  |  |  |  |
| --- | --- | --- | --- |
| Name of drug: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Name of drug: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Dosage: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Dosage: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |
| Name of drug: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Name of drug: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Dosage: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Dosage: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**ALCOHOL**

How many units of alcohol do you drink per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(1 unit = half pint of beer, 1 glass of wine, or a pub measure of spirits)*

**LANGUAGE**

Which is your main language?

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| English |  | Urdu |  | Punjabi |  | Hindi |  | Other (please state) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Polish |  | Arabic |  | Chinese |  | Gujerati |  |

**SMOKING**

Do you smoke? **Yes / No** If Yes, how many: Cigarettes per day \_\_\_\_\_\_\_\_

Cigars per day \_\_\_\_\_\_\_ Ounces of tobacco per day \_\_\_\_\_\_

How old were you when you started smoking? \_\_\_\_\_\_\_ (years)

**EX-SMOKERS**

How old were you when you stopped smoking? \_\_\_\_\_\_\_\_ (years)

How much did you smoke per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (cigarettes / cigars / oz. of tobacco) *Please delete as appropriate*

**PASSIVE SMOKING**

Are you exposed to smoke at work? **Yes / No** At home? **Yes / No**

**VACCINATIONS – Which vaccinations have you had and when?**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Tetanus\* | 🗌 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Polio\* | 🗌 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| BCG\* | 🗌 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | MMR\* | 🗌 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other\* (please specify) | 🗌 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  | \* Please specify dates |

**CARERS**

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

If ‘Yes’ - please provide the following information:

Your carer’s full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_

Your carer’s full address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Post Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

If “Yes”, ask the receptionist about Carers support

**ETHNICITY**

Please select the Ethnic group, which you feel describes you best, by ticking the appropriate box. If you select one of the ‘Any Other’ categories, please write in any additional information on the line provided.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **A: White** | **□** British | **□** Irish | **□** Any other\* White |  |
| **B: Mixed** | **□** White/Black Caribbean | **□** White/Black African | **□** White/Asian | **□** Any other\* mixed background |
| **C: Asian or Asian British** | **□** Indian | **□** Pakistani | **□** Bangladeshi |  |
| **D: Black or Black British** | **□** Caribbean | **□** African | **□** Any other\* Black |  |
| **E: Chinese or other ethnic group** | **□** Chinese | **□** Any Other\* |  |  |

**\* Details of ‘Other’ ethnic groups: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Summary Care Record**

If you are registered with a GP practice in England, you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past

You have the choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care. Your options are outlined below; please indicate your choice:

• Express consent for medication, allergies and adverse reactions only. You wish to share information about medication, allergies for adverse reactions only.

• Express consent for medication, allergies, adverse reactions and additional information. You wish to share information about medication, allergies for adverse reactions and further medical information that includes: your illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.

• Express dissent for Summary Care Record (opt out). Select this option, if you DO NOT want any information shared with other healthcare professionals involved in your care.

If you chose not to complete this consent form, a core Summary Care Record (SCR) will be created for you, which will contain only medications, allergies and adverse reactions. You are free to change your decision at any time by informing your GP practice.

**PATIENT CONSENT – *ADULTS* (aged 16+)**

I \*Mr/Mrs/Ms/Miss/Other (\*delete as appropriate) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Having read the above information regarding your choices, **please circle one of the options below**

**Yes – I would like a Summary Care Record** (You do not need to do anything and a Summary Care Record will be created for you).

**Undecided –** Enclosed is an opt out form. Complete the form and hand it in to the practice staff within 12 weeks. If you do nothing, we will assume that you are happy with these changes and create a SCR for you.

**No – I would not like a Summary Care Record** *Enclosed is an opt out form. Please complete the form and hand it to a member of the GP practice staff.*

**SIGNED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PRINT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATED: \_\_\_ / \_\_\_ /** 20 **\_\_\_**

**PATIENT CONSENT – *CHILDREN (*aged under 16)**

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

hereby submit my written consent for any Clinician/non-Clinician at the Birchills Health Centre to access my child’s records and arrange/refer for further care (e.g. - hospital admissions, community/hospital referrals etc) as he/she feels necessary in order to provide patient medical care and in accordance with Healthcare guidelines.

Having read the above information regarding your choices, **please circle one of the options below**

**Yes – I would like a Summary Care Record** (You do not need to do anything and a Summary Care Record will be created for you).

**Undecided –** Enclosed is an opt out form. Complete the form and hand it in to the practice staff within 12 weeks. If you do nothing, we will assume that you are happy with these changes and create a SCR for you.

**No – I would not like a Summary Care Record** *Enclosed is an opt out form. Please complete the form and hand it to a member of the GP practice staff.*

**SIGNED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PRINT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATED: \_\_\_ / \_\_\_ /** 20 **\_\_\_**

***Staff Use Only:***

*Form received and checked by: Date:*

