BIRCHILLS Health Centre

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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: _____

Mobile Number: _____(if you change it, please let us know)

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:*

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 (completed forms must be returned to your GP practice. Forms sent anywhere other than your GP practice will not be actioned).

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 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:

- phone the Summary Care Record Information Line on 0300 123 3020;
- contact your local Patient Advice Liaison Service (PALS); or
- contact your GP practice.

FOR NHS USE ONLY

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

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