**THE COUNTY PRACTICE**

**1330 Melton Road**

**Syston**

**Leicester LE7 2EQ**

**Tel: 0116 2950500**

**New Patient Registration Health Questionnaire**

Thank you for applying to join The County Practice. As a new patient to the practice we would like to ask you to complete the following questionnaire. This will assist in providing you with the best care. You must sign the form on the final page to confirm all the details given are correct. **All information given to us will be confidential and used only in accordance with statutory regulations, e.g. Data Protection Act/GPDR.**

UK residents and those residing in the UK for legal and settled purpose, AND living within the practice area, are entitled to register with us. We reserve the right to remove patients who do not live within our practice boundary. If you register with the practice and are not living in the area this will affect the services that we can provide for you, for example no home visits will be undertaken outside of practice boundaries. All patients found not to be living in the practice area will be removed from our list with 28 days notice. UK citizens who now live abroad for most of the year may not entitled to free NHS care. European Economic Area (EEA) rules

apply for those residing in a member state.

**For online registration purposes please supply a photographic form of ID.**

If you need any support in completing this form, please ask at the reception. If you have a disability, which means you need information in a different way please contact the surgery and fill in an Accessibility Contact Form.

Please complete all areas that are applicable to you or your child in **CAPITAL LETTERS** and tick the appropriate boxes.

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name |  |  | Date of Birth |
| Mobile Telephone Number |  | Email Address |
| Single [ ]  Cohabiting [ ]  Widowed [ ] Married [ ]  Divorced [ ]  Separated [ ] Civil partnership [ ]  |  | Occupation  |

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| --- |
| \*Main spoken languages |
| [ ]  **English** |
| [ ]  **Other** (please specify) |
| Interpreter required? |
| [ ]  Yes | [ ]  No |

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| \*What is your ethnic group? (please circle the option that best describe your ethnic group or background) |
| **White** |  | English/Welsh/Scottish |  | Northern Irish |  | Irish |
| **BlacK** |  | Caribbean |  | African |  | Other |
| **Asian** |  | Indian |  | Pakistani |  | Chinese |
| **Mixed** |  | White + Black Caribbean |  | White + African |  | White + Asian |
| **Other** *Please specify***:** |  |

**Next of kin**

|  |  |  |
| --- | --- | --- |
| Name of next of kin |  | Relationship to you/child |

|  |  |  |
| --- | --- | --- |
| Next of kin telephone number(s) |  | Next of kin address (if different to above) |

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| **Are you a Military Veteran?**[ ]  Yes [ ]  No  |

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| Do you have a Carer? [ ]  Yes [ ]  NoIf yes, what is their name and contact number? |

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| Are you a Carer? [ ]  Yes [ ]  NoIf yes, do you look after someone who is a patient of ………………? [ ]  Yes [ ]  NoIf yes, what is their name?What is your relationship to them?If No, please give the address of the surgery or the name of the GP who treats the person you care for:We will refer you to the Carers Service (……………. Carers) for further information and support. Please tick if you do **NOT** wish to be referred [ ] …………….Carers provides information and advice and free services such as gym sessions, sitting service, holidays and emotional support. |

|  |  |
| --- | --- |
| Are you an Adult with social care involvement?[ ]  Yes [ ]  No  | If yes, please state the reason why |
| Do you have a nominated patient advocate/advocacy service or Lasting Power of Attorney? [ ]  Yes [ ]  NoDetails ………………………………. |

**If Registering a Child please complete the following:**

**If you are applying on behalf of a child who is in foster care/residential care/Kinship care/ or who is not your child:**

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| --- | --- | --- |
| Who has the parental or legal responsibility for the child?[ ]  You as the legal parent/guardian/adoptive  parent[ ]  **Other** (please specify)Name:Contact Number:Evidence of parental responsibility ( birth certificate/social care information) :  |  | If you are the parent/guardian/foster carer /kinship carer **but cannot** consent please detail below who canName:Relationship to child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contact Number: |
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**Looked after Children**

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| If a child, are they looked after? [ ]  Yes [ ]  NoIf Yes, under what arrangements:[ ]  Section 20-Voluntary Care [ ]  Subject to an Interim Care Order [ ]  Subject to a Full Care Order [ ]  Placed for adoption [ ]  Unaccompanied Asylum Seeker  |
| [ ]  Private arrangement/Private Fostering/informal arrangement(please note you have a duty to notify social care of this arrangement) ***What is Private Fostering?***A private fostering arrangement is one that is made without the involvement of the Local Authority to look after a child under the age of 16 (or under 18 if disabled) by someone other than a parent or close relative, for 28 days or more and can include those living with extended family members. So, this could be a child living with people as stated below:

|  |  |
| --- | --- |
| *Private Fostering* ***includes*** *a child living with:* | *Private Fostering* ***does not include*** *a child living with:* |
| * godparents
* great-grandparents
* great aunts or uncles
* family friends
* step parents where a couple isn't married or in a civil partnership
* cousins
* a host family which is caring for a child from overseas while they are in education here
 | * brothers
* sisters
* grandparents
* aunts
* uncles
* step parents where a couple is married or in a civil partnership
* mother
* father
* children and young people who are being looked-after by the Local Authority
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| --- | --- |
| Name of school or nursery: | Home schooled. [ ]  |
| Does the child have a social worker?**[ ]  Yes [ ]  No** | Name of Social Worker: |
| Are there any other Agencies involved in their care? **[ ]  Yes [ ]  No. Contact Details:**  |

**Medical details**

**Please provide information below if known**

**If over 18 please provide recent BP reading.**

 **This can be taken on one of the practice machines**

 **BP reading :**

**If BP > 140/90 please arrange 5 day BP reading at reception**

|  |
| --- |
| Height m cm |
| Weight kg |

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| --- |
| **For women aged 25 to 64**) Have you had a cervical smear test?  |
|  |
| [ ]  Yes [ ]  No |
|  |
| If Yes Please state where, when and the result(if known) |
|  |

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| Do you have any current health problems, please include dates? ( Asthma, COPD, Diabetes, Heart Disease, Learning disabilities, mental health problems ) **If you have any of the above please make an annual review appointment.** |

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| Are you taking any medication? [ ]  Yes [ ]  NoPlease provide repeat prescription or list of medication from previous practice. |
| **If you are a patient on repeat medication please make a medication review appointment.**  |

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| Are you allergic to any medicine or other substance? [ ]  NO [ ]  YES - please list below |
| 1. | 3. |
| 2. | 4. |

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| --- | --- | --- | --- |
| Family History |  |  |  |
| Only tick if these apply to first degree relatives. i.e parents and siblings. | Asthma [ ]  | Diabetes [ ]  | Heart disease [ ]  |
| High Blood Pressure [ ]  | Stroke/Mini Stroke [ ]  | Skin conditions [ ]  |
| Depression [ ]  | Peptic ulceration [ ]  | Thyroid Disorder [ ]  |
| Eyesight problems [ ]  | Asthma/COPD [ ]  | Cancer [ ]  |

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| Do you drink alcohol? Yes [ ]  No [ ] If yes please answer questions below : |
| 1. Have you ever felt you should CUT down your drinking? [ ]
2. Have people ANNOYED you by criticising your drinking? [ ]
3. Have you ever felt bad or GUILTY about your drinking? [ ]
4. Have you ever had a drink first think in the morning to steady your nerves or get rid of a hangover (EYE- opener)? [ ]

**If you tick 2 or more boxes please make a Telephone Consultation with a GP**  |
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| \* What are your smoking habits? [ ]  Smoker [ ]  Ex-Smoker [ ]  Never SmokedHow many do you smoke a day? **\_\_\_\_\_\_\_\_\_\_\_\_**Would you like advice on quitting? [ ]  Yes [ ]  No |

**Lifestyle:**

**How would you describe your diet? What are your exercise habits?**

|  |  |  |
| --- | --- | --- |
| [ ]  Good diet | [ ]  Exercise impossible |  |
| [ ]  Average diet | [ ]  Light exercise | In what form:  |
| [ ]  Poor diet | [ ]  Moderate exercise | In what form: |
| [ ]  Vegetarian / Vegan | [ ]  Heavy exercise | In what form: |

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| **Immunisations**If you are from abroad please give a copy of your immunisations.If a child - are they up to date with their immunisations? [ ]  Yes [ ]  No (if no please specify) |

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| **Domestic Abuse: If domestic abuse is affecting your health you can speak to someone here.** **Please tick this box if you would like a GP to contact you.** [ ]  |

**On-line services**

If there are any problems with your registration we will contact you to clarify any issues, but once your details have been entered into our computerised records you will be able to register with our **on-line service** provider (System One) and access appointments, prescriptions and some sections of your own medical record via the internet.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Application for online access to my medical record**I wish to access my medical record online and understand and agree with each statement (please tick)

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the practice
 | [ ]  |
| 1. I will be responsible for the security of the information that I see or download
 | [ ]  |
| 1. If I choose to share my information with anyone else, this is at my own risk
 | [ ]  |
| 1. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement
 | [ ]  |
| 1. 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
 | [ ]  |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **On-line account**Scan to Patient Record

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| I wish to have access to the following online service (tick all that apply) |
| 1. Booking appointments
 | [ ]  |
| 1. Requesting repeat prescriptions
 | [ ]  |
| 1. Accessing my medical records
 | [ ]  |

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| **Text reminders for appointments**

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| Would you like to receive text reminders for appointments? | Yes [ ]  No [ ]  |
| I consent to the practice contacting me by text message and/or e-mail for the purposes of health promotion, practice news and appointment reminders. I acknowledge that the appointment reminders by text are an additional service and that they may not be sent on all occasions and the responsibility for attending appointments or cancelling them still rests with me. I can cancel the text message facility at any time. Text messages are generated using a secure facility but I understand that they are transmitted over a public network onto a personal telephone and as such may not be sure, however, the practice will not transmit any information which would enable an individual patient to be identified. **I agree to advise the practice if my mobile number changes or if it is no longer in my possession.** |

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**Data Sharing**

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| **Summary Care Record (SCR)**The SCR is a summary of your medical history that can be shared between healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information. **More information can be found by visiting** [**www.nhscarerecords.nhs.uk**](http://www.nhscarerecords.nhs.uk) **and *practice website*** **Tick this box if you wish to opt-in to the SCR** [ ] **Tick this box if you wish to opt-out of the SCR** [ ] Please collect an opt out form reception or download a form from ***practice website*** |

#### ****National Data Opt-out****

Due to the introduction of the General Data Protection Regulation (GDPR) in May 2018 there have been national changes on how patients record their preference as to how they would like their data shared.

**More information can be found by visiting the** **NHS website** <https://www.nhs.uk/your-nhs-data-matters/> . You can update your preferences there.

**Electronic Prescription Service (EPS)**

All prescriptions will now be sent electronically.

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| Please nominate a pharmacy:*(So we can send your prescription direct to them)* |
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| --- | --- | --- |
| **\*Signed** |  | **\*Date** (dd/mm/yyyy) **/ /** |

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| **Signed on behalf of patient** (*if applicable*) **Full Name:**(Minors under 16 years old, adults lacking capacity)  |
|   **Relationship:** |

**Thank you for providing this information. We look forward to providing you with a high standard of care in a friendly and professional manner.**

**Please take a copy of our practice leaflet.**