EAST BARNWELL HEALTH CENTRE

NEW PATIENT QUESTIONNAIRE

Please complete this questionnaire the best you can, the more information we have, the better we can help you. When you have completed the form, please return it to Reception, along with **Photo ID and Proof of address**.

PERSONAL DETAILS	
Title (Please circle as appropriate): Mr / Mrs / Miss / Ms / Other	
First Name(s):	**Date of Birth:**
Surname:	**Sex:**
Previous Surname(s):	**Occupation:**
Marital status: Single / Married / Cohabiting / Separated / Divorced / Widowed	

CONTACT DETAILS	
Home Address:	**Home Tel:**
	Mobile Tel:
Email:	**Work Tel:**
I consent to the practice contacting me on occasion by text/email for the purpose of health promotions and for appointment reminders: YES / NO	
Next of Kin:	**Relationship:**
Next of Kin Contact Details:	

PREVIOUS GP	
Name of previous GP Practice:	**Telephone:**
Address:	

CARERS	
Do you look after or support someone who is ill, frail, disabled or mentally ill?	YES / NO
Are you looked after or supported by somebody because you are ill, frail, disabled or mentally ill?	YES / NO
Would you like your carer to deal with your health affairs here?	YES / NO
If you answered 'yes' to any of these questions, please ask the receptionist for our Carer's leaflet which includes information about support available for Carers	

ARMED FORCES	
Have you served with the armed forces (Army/Navy/Air force/other)?	YES / NO
Have any of your close family members served in the armed forces?	YES / NO
If yes, which family member?	

ETHNICITY, RELIGION & LANGUAGE	
Ethnic Origin (please circle as appropriate):	
White	British /Irish / Other
Mixed	White & Black Caribbean / White & Black African / White & Asian / Other
Asian or Asian British	Indian / Pakistani / Bangladeshi /Chinese / Other
Black or Black British	Caribbean / African / Other
Other, please state:	
Religion:	
First Language:	
	Do you need an interpreter for your appointments? YES / NO

PERSONAL HEALTH					
Height:		**Weight:**			
Smoking Status: Current Smoker / Ex-smoker / Never Smoked					
For Current/Ex-smokers:	**How many cigarettes per day?**				
	How old were you when you started?				
	Approximate age when stopped:				
If you would like help to give up smoking please enquire at reception for details of our smoking cessation services.					
Alcohol Consumption: (Please circle as appropriate)					
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 <u>units</u> of alcohol do you have on a typical day when you are drinking? (1 unit= 1 glass wine/ half pint beer)	1-2	3-4	5-6	7-8	10+
How often do you have 6 or more <u>units</u>, if female or 8 or more <u>units</u>, if male on one occasion?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
Do you exercise regularly?	YES / NO If yes, approximately how many hours per week? ……				

PRE-EXISTING MEDICAL CONDITIONS	
Do you personally suffer from any of the following conditions?	
Breathing problems for which you are currently treated with inhalers eg Asthma, bronchitis	YES / NO
High blood pressure / on treatment for high blood pressure	YES / NO
Epilepsy for which you are currently taking treatment	YES / NO
Diabetes	YES / NO

PERSONAL & FAMILY MEDICAL HISTORY		
Have you had any of the following in the past or currently? (Please circle as appropriate)		
Heart attack / angina		YES / NO
Stroke / mini stroke / Transient Ischaemic Attack (TIA)		YES / NO
Do you have any allergies? (If yes, please state)	**Medication:** YES / NO	
	Animals: YES / NO	
	Other: YES / NO	

Date of last blood pressure check:	
Date of last cholesterol check:	

Is there any history of the following in your family before age of 65?
(If yes, please state which family member)

Heart Disease (hearts attacks, angina)	YES / NO	
Stroke	YES / NO	
Cancer	YES / NO	

VACCINATION HISTORY

Date of last flu vaccination:	
Date of pneumococcal vaccination:	
Date of last tetanus vaccination:	

Where possible, please provide a list of vaccinations from your previous surgery.

MEDICATIONS

Please list any medications you regularly take:

If you have a list of repeat medication, please hand this in at reception.

Nominated Pharmacy: **Which pharmacy would you like to collect your prescriptions from?**	

If you have medication on repeat, please make an appointment to speak with a GP before your next prescription is due. If you take the oral contraceptive pill, please book appointment for a pill check with the Practice Nurse.

FEMALE PATIENTS

Would you like to receive advice on contraception from the Practice?		YES / NO
Have you had a cervical smear?	YES / NO	Date:
What was the result?	Normal / Abnormal	
Was this test taken outside the UK?	YES / NO	
Have you had a Hysterectomy	YES / NO	Date:
Have you ever had a Mammogram? **Was it normal?**	YES / NO YES / NO	Date:
Have you ever been pregnant? **Were there complications?** **Are you currently pregnant?**	YES / NO YES / NO YES / NO	How many times? How many weeks?

SUMMARY CARE RECORD

Your summary care record will be used in an emergency. The record will contain information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had to ensure those caring for you have enough information to treat you safely.
If you do not want a summary care record, please ask at reception and complete the SCR Opt-out form.

Thank you for taking the time to complete this questionnaire - Please make sure you have completed all the forms and sign below.

New Patient Registration Checklist:

GMS1 Registration Form☐
New Patient Questionnaire ☐
Online Services Form ☐
Sharing Record Form ☐
Photo ID ☐
Proof of Address ☐

Signature of patient:	
Date:	

To be completed by receptionist:

Primary ID seen and signature verified: (Passport / Driving License)		**Secondary ID seen and address verified: (utility bill)**	
Registering GP: Dr……..	**Informed Yes / No**	**Smoking cessation**	**Informed Yes / No**

Questionnaire to be scanned into patient's medical record

EAST BARNWELL HEALTH CENTRE

Patient Online Services Information Leaflet & Registration Form

In addition to telephoning or visiting the practice, we have a range of online services to help improve access, which are available for you to:

- Book your next GP appointment online
- Request repeat prescriptions for any medication you regularly take
- View your medical record

How do I get started? First of all, you must complete the registration / consent form (see overleaf), which you need to return to the practice in person along **with two forms of identification**.
One form of identification must be **photographic: such as passport or driving licence, etc**. The second form of identification must be **non-photographic such as a utility bill or bank statement, etc**. We will be unable to process the request, without the correct forms of identification.

How long does it take to receive my login details? It will take us between 5 - 10 working days to process your request. We will then send you your user details to register online by email.
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Things to consider before requesting to view your records online

Forgotten history There may be something you have forgotten about in your record that you might find upsetting.
Abnormal results or bad news If your GP has given you access to test results or letters, you may see something that you find upsetting to you. This may occur before you have spoken to your doctor or while the surgery is closed.
Choosing to share your information with someone It is up to you whether or not you share your information with others – perhaps family members or carers. It's your choice, but also your responsibility to keep the information safe and secure.
Coercion If you think you may be pressured into revealing details from your patient record to someone else against your will, it is best that you do not register for access at this time.
Misunderstood information Your medical record is designed to be used by clinical professionals to ensure that you receive the best possible care. Some of the information within your medical record may be highly technical, written by specialists and not easily understood.
Information about someone else If you spot something in the record that is not about you or notice any other errors, please log out of the system immediately and contact the practice as soon as possible.
Keeping your information safe and secure It is **your responsibility** to keep your login details and password safe and secure. If you know or suspect your record has been inappropriately accessed, you should change your password and contact the practice. We would recommend you do not print anything from your record unless you are sure you can keep printed copies safe.

Disclaimer
All data is protected using the highest standard internet security; so, you can be sure all your personal information is safe and secure.

Registration to GP online services

Surname			
First name			
Date of birth			
Address (Incl. Postcode)			
*Email address††			
*Mobile number		Telephone number	

††*We will send your registration ID to the email address provided above and add it to your medical record.*

**By providing your mobile number and/or your email address you are consenting to receiving electronic communications regarding your personal health care from us, which may be deemed confidential.*

I wish to have access to the following online services (tick all that apply):

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. Accessing my medical record	☐

If I choose to access my medical record online and understand and agree with each statement below:

1. I have read and understood the information leaflet provided by the practice
2. I will be responsible for the security of the information that I see or download
3. If I choose to share my information with anyone else, this is at my own risk
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement
5. If I see information in my record that it not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible

Signature		Date	

For practice use only

	Photo. ID	Non-Photo. ID	Verifier:	Date:
Identity verified through (tick all that apply)	Driving Licence ☐ Passport ☐ Bus Pass ☐ Other (specify below) ☐	Utility Bill ☐ Bank Statement ☐ Other (specify below) ☐		
Name of person who authorised:			Date:	
Date account created:				