**NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE**

To the Patient:

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. New Patients may be required to attend a New Patients Health Check with the Practice Nurse, on completion of this form please check with Reception staff if you need to book an Appointment.

Date of completion of this form: …………………………………………………………………….

Surname: ………………………………………………….. Forename(s): …………………………

Date of Birth: ……………………………………………… Marital status: ….…………………….

Address: ………………………………………………………………………………………………

……………………………………………………………….… Postcode: ………………………..….

PHONE. Home: ……………………………………………..…… Mobile: ……………………….…

**Permission to be sent Text Messages**. Confirmation of appointments, reminders **Yes/No**

Skype Contact/Name …………………………………………………………………………………

Email address: …………………………………………………………………………………………

Occupation: …………………………………………………………………………………………….

Next of Kin: Name: ………………………………………. Tel: ……………………………………...

Relationship to patient: …………………………………..

Weight (approx.): ……………………………………….. Height: …………………………………..

If this registration is for a child (up to 16yrs) are they looked after (in care) Yes / No

**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? …………………..

Are you interested in stopping smoking? Yes..... No..... (tick as appropriate)

**EX-SMOKERS**

How old were you when you stopped smoking? …………………

How much did you smoke per day? …………………………………..

**PASSIVE SMOKING**

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

|  |  |
| --- | --- |
| **This is one unit of alcohol…** | **Each of these is more than a unit** |

|  |  |  |
| --- | --- | --- |
| **Weekly Alcohol Consumption** |  |  |
| How many alcohol units do you drink per week? |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **FAST questions** | **Scoring system** |  | **Your score** |
| **0** | **1** | **2** | **3** | **4** |  |
| 1. How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?
 | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |  |
| **If your score is 0, 1 or 2 for question A continue with the next three questions.If you have scored 3 or 4, stop here.** |  |  |
| 1. How often during the last year have you failed to do what was normally expected from you because of your drinking?
 | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |  |
| 1. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
 | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |  |
| 1. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?
 | No |  | Yes, but not in the last year |  | Yes, during the last year |  |  |
| 1. **FAST SCORE (A+B+C+D)**
 |  |  |

|  |  |  |
| --- | --- | --- |
| **If your FAST SCORE is 3 or more continue with the remaining questions.** |  |  |
| **AUDIT QUESTIONS** | **Scoring system** |  | **Your score** |
| **0** | **1** | **2** | **3** | **4** |  |
| 1. How often do you have a drink containing alcohol?
 | Never | Monthlyor less | 2 - 4 times per month | 2 - 3 times per week | 4+ times per week |  |  |
| 1. How many units of alcohol do you drink on a typical day when you are drinking?
 | 1 -2 | 3 - 4 | 5 - 6 | 7 - 8 | 10+ |  |  |
| 1. How often during the last year have you found that you were not able to stop drinking once you had started?
 | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |  |
| 1. How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?
 | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |  |
| 1. How often during the last year have you had a feeling of guilt or remorse after drinking?
 | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |  |
| 1. Have you or somebody else been injured as a result of your drinking?
 | No |  | Yes, but not in the last year |  | Yes, during the last year |  |  |
| **AUDIT SCORE (E+F+G+H+I+J+K)** |  |  |

**TOTAL AUDIT Score (all 10 questions completed):**

|  |  |  |  |
| --- | --- | --- | --- |
| **0 – 7** | **8 – 15** | **16 – 19** | **20+** |
| Lowerrisk | Increasingrisk | Higherrisk | Possibledependence |

**EXERCISE**

Do you take regular exercise? Yes / No.

Enjoy light exercise

Enjoys moderate exercise

Avoids even trivial exercise

Exercise physically impossible

**FAMILY HISTORY**

Is there any of the following in your family *(father, mother, brother, sister)* before age of 65?

Asthma Yes / No which family member? ................................

Diabetes Yes / No which family member? ................................

Heart Disease (heart attacks, angina) Yes / No which family member? ………….………….

Stroke? Yes / No which family member? ………….………….

Cancer? Yes / No which family member? ………….………….

 Site of cancer? …………………………………………

**MEDICATION**

Please provide details of any medication which you take (prescribed or otherwise) please provide us with a copy of your repeat medications slip.

**ALLERGIES**

Are you allergic to anything e.g. medication, animals, substances or foods? Yes / No

If yes, please give details: ……………………………………………………………………………………………………………

……………………………………………………………………………………………………………

**EQUAL RIGHTS DATA**

|  |
| --- |
| **ETHNIC ORIGIN** – I would describe my ethnic origin as follows:(please tick as appropriate) |
| **White**[ ] British[ ] Irish[ ] Any other White[ ]  background | **Mixed**[ ] White and Asian[ ] White and Black African[ ]  White and Black Caribbean[ ] Any other mixed background | **Other Ethnic Group**[ ]  Chinese[ ] Any other ethnic group |
| **Black or Black British**[ ] African[ ] Caribbean[ ] Any other Black[ ] background | **Asian or Asian British**[ ] Bangladeshi[ ] Indian[ ] Pakistani[ ] Any other Asian background | [ ]  I do not wish to disclose my ethnic origin |

**RELIGIOUS AFFILIATION**……………………………………………………………………………

**MAIN SPOKEN LANGUAGE** ………………………………………………………………………..

**Patient Participation Group.**

We are currently reviewing our patient group, hoping to extend this and involve a wider patient representative, you can be involved as much or as little as you like, we plan to hold Monthly meeting with an agenda about patient care and services that the practice and wider community of York provide this can even be done from the comfort of your own home by using our patient intranet.

Would you like to be kept informed of when the meetings occur? **Yes/No**

Would you like access to our Patient online group? **Yes/No**

**This is your chance to have your say about the services you receive.**

**If you answered yes we will send you further information how to join.**

**CARERS**

Do you look after a friend or relative with an illness or disability? This may involve staying at home to look after them, helping them with cooking or shopping or personal care or taking them to hospital. If you do then you may be a carer. A carer is someone of any age, who provides unpaid support to a family member, partner or friend who could not manage without your help.

Old School Medical Practice would like to support you in your caring role by putting you in touch with the Carers Resource – a FREE, independent and confidential service for carers which will provide information on many caring issues such as specific illnesses / disabilities, short breaks and holidays and can signpost you to other local organisations which may help you.

The Carers Resource also has a specialist Emergency Planning Service to help you create a contingency plan in case of an emergency. You may be reassured by knowing that the person you care for will be looked after if you were suddenly taken ill.

**So, please remember to:**

**√ Tell your GP that you are a carer**

**√ Talk to your GP about your own health**

**√ Ask if your GP has any leaflets which may help you in your caring role**

Old School Medical Practice is also interested in hearing your personal views on how it feels to be in a caring role and may be holding a Carers’ Focus Group in the near future.

If you would be willing to take part in the group, please tick this box:

If you consent to your name, address and telephone number being given to the Carers’ Resource in York so that they may send you information about their specialist services for carers, please tick this box:

We would like to know if you are a carer so we can help you to look after ***yourself*** as well as the person you care for. We can make a note on your record that you care for someone.

**ARE YOU A CARER:** Yes/No

**What is the name of the person you look after?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is he/she a patient at Old School Medical Practice? Yes / No

**ONLINE REGISTRATION**

Would you like to register for our online services: YES / NO

You can book appointments and order your regular repeat medication, view your summary record and more. Please complete the attached registration form and hand to the reception staff who will provide you with a username and password.

Internal Use Only

New Patient Health Check been offered Checks/ by …………../date…………..

New Patient Health Check Booked Data entered………..../date.................

Is the patient a carer

Does the patients have a carer Scanned onto System by ……………

Patients identification checked

Patient home addressed check

Patient online registration completed

Dear Patient,

**Patient choices regarding sharing of health records**

Electronic records are kept in all the places where you receive healthcare. Often, NHS care services can usually only share information from those records by letter email, fax or phone. At times, this can slow down your treatment and mean information is hard to access.

This service uses a secure computer system that allows the sharing of full electronic records across different NHS care services. This form is **not** about your Summary Care Record (SCR), it is asking your sharing preferences regarding your full detailed electronic record.

We are telling you about this, as you have a choice to make. You can choose to share or not to share your full electronic record with other NHS care services where you are treated and whether we can view records held by those other services.

If you choose to make your record shareable, ***your clinical details will only viewable by clinical teams who are treating you. Each clinical team which cares for you now or in the future will ask your permission to view your shared record.*** You can also ask for part of your record to be made private – not shareable. All record accesses are recorded and auditable.

If you choose not to make your records shareable, we will respect your wishes and will do our best to make your care safe and efficient. However, ***denying the clinical teams caring for you the ability to access important clinical details could compromise your care***.

If you require further information please ask at reception. You can also visit the NHS Care records website at <http://www.nhscarerecords.nhs.uk/carerecords> or download the NHS Care Record Guarantee from <http://www.nigb.nhs.uk/pubs/nhscrg.pdf>.

**Q: How is my decision recorded?**

A: You have two choices:

**Sharing Out** – This controls whether your full electronic patient record can be shared with other NHS care services where you are treated. Please record your preference:

**Please tick: Sharing Out** **Yes**(shareable)□ or **No** (not shareable)□

**Sharing In** – This controls whether you agree for this practice to view information you’ve agreed to share at other NHS care services. Please record your preference:

**Please tick: Sharing In** **Yes**(viewable)□ or **No** (not viewable)□

Patient Name (Print Name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ NHS Number (if known) \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

 Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

 

**Your emergency care summary**

Dear Patient

**Summary Care Record – your emergency care summary**

The NHS in England is introducing the Summary Care Record, which will be used in emergency care.

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.

Your Summary Care Record will be available to authorised healthcare staff providing your care anywhere in England, but they will ask your permission before they look at it. This means that

if you have an accident or become ill, healthcare staff treating you will have immediate access to important information about your health.

Your GP practice is supporting Summary Care Records and as a patient you have a choice:

• **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.

• **No I do not want 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**.

If you need more time to make your choice you should let your GP Practice know.

For more information talk to our Patient Advice and Liaison Service (PALS) (**0800 0525 270),** visit the website **www.nhscarerecords.nhs.uk** or telephone the dedicated NHS Summary Care Record Information Line on 0300 123 3020.

Additional copies of the opt out form can be collected from the GP practice, printed from the website **www.nhscarerecords.nhs.uk** or requested from the dedicated NHS Summary Care Record Information Line on 0300 123 3020.

**You can choose not to have a Summary Care Record and you can change your mind at any time by informing your GP practice.**

If you do nothing we will assume that you are happy with these changes and create a Summary Care Record for you. Children under 16 will automatically have a Summary Care Record created for them unless their parent or guardian chooses to opt them out. If you are the parent or guardian of a child under 16 and feel that they are old enough to understand, then you should make this information available to them.

Yours sincerely

The Old School Medical Practice

