MAPLES FAMILY MEDICAL PRACTICE

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If you need any support in completing this form, please ask at reception

Thank you for applying to join Maples Family Medical Practice. We would like to gather some information about you and ask that you fill in the following questionnaire. You don't have to supply answers to all of the questions but what you do fill in will help us give you the best possible care. **Please supply two forms of Identification with your completed form, a photographic form of ID (such as passport or driving licence). If you do not have photographic ID then please bring your birth certificate and proof of your home address (such as a recent bank statement or document relating to your new home with your name on).**

Please complete all areas in **CAPITAL LETTERS** and tick the appropriate boxes. Fields marked with an asterix (*) are mandatory.

*Title *First names	* Any previous surname(s)
*Surname	Town and country of birth
*Gender Identity. Woman including trans woman ☐ Man including trans man ☐ non-binary ☐ Other ☐ *Is your gender identity the same as you were assigned at birth YES ☐ NO ☐	*NHS No. ☐☐☐☐☐☐☐☐☐☐ (if known)
*Sexual orientation Heterosexual or Straight ☐ Gay or lesbian ☐ Bisexual ☐ Other ☐	*Home address
*Date of Birth	
*Home telephone No.	*Postcode
*Mobile No.	Email address

Previous address and doctor's details

*Previous address in the UK Postcode	Name of previous doctor/GP surgery while at previous address
	Address of previous doctor

If you are from abroad

*Your first UK address where you registered with a GP Postcode	*If previously a resident in the UK, date of leaving
	*Date you first came to live in the UK if applicable

Please tick If you are returning from the Armed Forces. Military ☐ Navy ☐ Air Force ☐ Marine ☐ Veteran ☐ Reservist ☐ Family member ☐

Address before enlisting Postcode	Service or Personnel No.
	Enlistment date

Additional details about you

*What is your ethnic group? (Choose an 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
Traveller	☐	*Other* _____				

*Main spoken languages

☐ **English**

☐ **Other** (please specify)

_____

Interpreter required?

☐ Yes ☐ No

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

Who has the legal responsibility for the child?

☐ You as the legal parent or guardian

☐ **Other** (please specify)

_____

Who can consent for medical treatment for the child?

☐ You as the legal parent or guardian

☐ **Other** (please specify)

_____

Looked after Children

Are you looking after someone else's child? ☐ Yes ☐ No

If Yes, under what arrangements:

☐ Section 20-Voluntary Care ☐ Interim Care Order ☐ Care Order

☐ Child arrangement order/Residence Order ☐ Special Guardianship order ☐ Placed for adoption

☐ Private arrangement/Private Fostering/informal arrangement (**please note you have a duty to notify social care of this arrangement**)

Data Sharing

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

Tick this box if wish to opt-out of the SCR ☐

*Do you consent to receive the following types of communication from Maples Family Medical Practice?

Email ☐Yes ☐No

Mobile phone text messages ☐Yes ☐No

Answering machine messages ☐Yes ☐No

Medical Interoperability Gateway (MIG)
Whilst the SCR mentioned above shares a very small portion of your medical record across the whole NHS, the MIG shares a much fuller view of your records but only with local NHS providers – and only when you give explicit consent at the point of care.
For more information please visit our website at http://www.maplesfamilymedicalpractice.nhs.uk
Tick this box if you wish to opt-out of the MIG ☐

Do you have a Carer? ☐Yes ☐No
If yes, what is their name and contact number?
Do you consent for your carer to be informed about your medical care? ☐Yes ☐No

Are you a Carer? ☐Yes ☐No
If yes, do you look after someone who is a patient of Maples Family Medical Practice? ☐Yes ☐No ☐ Don't know
If yes, what is their name?
Are they a: ☐Relative ☐Friend ☐Neighbour
Please pass my information onto the Carer's Service ☐Yes ☐No
Please refer me to Adult Care Services for a carer's assessment ☐Yes ☐No

Next of kin

Name of next of kin

Relationship to you

Next of kin telephone number(s)

Next of kin address (if different to above)

Medical details

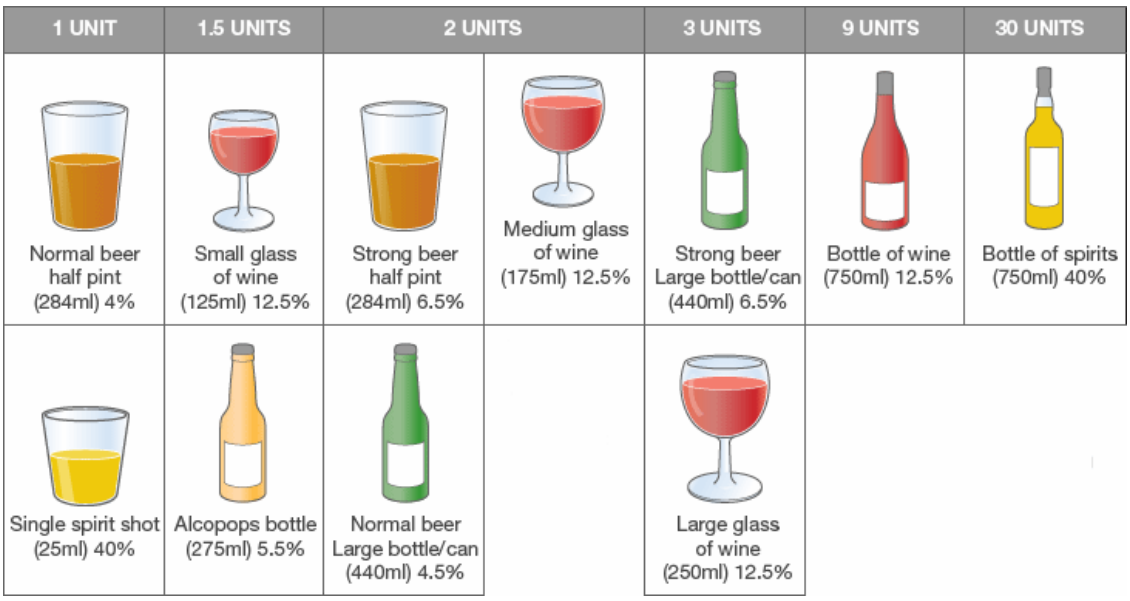
In order to continue to receive your repeat medications you will need to make an appointment with a GP at least one week before your next prescription is due.

*Are you allergic to any medicines? ☐ Yes ☐ No (if yes please specify)

**List other allergies (pollen, animal hair or certain foods. Please mark "none" if you have no other allergies that you know of)

Please tell us about your alcohol consumption

Questions (please circle your answers)	**Unit scoring system**				
	0	**1**	**2**	**3**	**4**
How often do you have a drink containing alcohol?	Never (go to Page 4)	Monthly or less	2 - 4 times Per month	2 - 4 times per	4+ times per week
How many units of alcohol do you drink on a typical day when you are drinking?	1 - 2	3 – 4	5 – 6	7 – 9	10+
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
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
How often during the last year you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
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
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
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
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
Has a relative or friend, Doctor or other Health worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year



Please tell us about your smoking habits

Do you smoke? ☐ Yes ☐ No Are you an Ex-Smoker ☐ Yes When did you quit? _____

If Yes, what do you primarily smoke:

☐ Pipe ☐ Cigarettes ☐ Cigar ☐ E Cigarette ☐ Other – Please specify _____

How many do you smoke a day? _____ Would you like advice on quitting? ☐ Yes ☐ No

Lifestyle (Please Tick ✓)

Exercise:

Light ☐ Moderate ☐ Heavy ☐ Unable ☐

Diet:

Vegetarian ☐ Vegan ☐ Normal ☐ Diabetic ☐

Do you use any form of contraception?

☐Yes ☐No

If Yes please specify _____

(For women aged 25 to 64 years)

Have you had a cervical smear test?

☐Yes ☐No

If Yes please state where/when/result (if known)

_____

Have you ever had any of the following conditions? (Please Tick ✓)

	✓			✓	
Epilepsy		Year	DVT		Year
High Blood Pressure		Year	Mental Illness (Inc. Depression)		Year
Heart Attack		Year	Diabetes (Type 1 or Type 2)		Year
Angina (stable/unstable)		Year	Asthma		Year
Stroke		Year	COPD		Year
Transient Ischaemic Attack		Year	Osteoporosis		Year
Cancer		Year	Peripheral Vascular Disease		Year
Rheumatoid Arthritis		Year	Thyroid Disorder		Year

Do you have a family history of any of the following? (Please Tick ✓)

	✓			✓	
High Blood Pressure		Who	DVT / Pulmonary Embolism		Who
Ischaemic Heart Disease Diagnosed aged >60yrs		Who	Breast Cancer		Who
Ischaemic Heart Disease Diagnosed aged <60yrs		Who	Any Cancer Specify type:		Who
Raised Cholesterol		Who	Thyroid Disorder		Who
Stroke		Who	Diabetes		Who
Asthma		Who	COPD		Who
Osteoporosis		Who	Mental Health Disorder		Who
Epilepsy		Who	Kidney Disease		Who

Please provide information below if known

Height	ft	in
Or	cm	
Weight	kg	
Or	st	lbs
Blood Pressure (BP machine is located in waiting room)		
BP (systolic/diastolic)	/	mmHg
Pulse		bpm

Do you have any communication needs due to disability, impairment or sensory loss, to help us to make sure that you receive communication in a format that you can understand?

Yes ☐ No ☐ If Yes, please provide further details

_____

Please record any additional information about you that you think is important for us to know

(Additional information includes: **Social worker** involved with your family; **legal parental responsibilities** of minor under 16 years old; applicant is in **foster care** or is **adopted**; if you are from **overseas** and **claiming asylum** or are a **refugee**)

NHS Organ Donor Registration

"I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death". Please tick the boxes that apply.

☐ **Any** of my organs and tissue or:

☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

For more information, please visit the website *www.uktransplant.org.uk* or call 0300 123 23 23

***Signed**	***Date** (dd/mm/yyyy) / /

***Signed on behalf of patient** (*if applicable*)
(Minors under 16 years old, adults lacking capacity)

***Full Name:**

***Relationship:**

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. All of the details that you need for this are available on our practice website on the 'appointments' and 'prescriptions' icons on the home page.

New Patient Health-check

You will be eligible for a new patient health-check with a Practice Nurse/Health Care Assistant. Contact reception if you would like to take this up (Recommended).

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

Please take a copy of our practice leaflet.

FOR OFFICE USE ONLY

Appointment made for New Patient Health Check ☐ **Date: _____**

FOR OFFICE USE ONLY

PHOTO ID/Birth Certificate (Over 18 only) ☐ **TYPE: _____**

ADDRESS ID ☐ **TYPE: _____**

Other ☐ **TYPE: _____**