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| **The Ruddington Medical Centre**  **Thank you for taking the time to complete this medical questionnaire, the information you provide will help improve our service to you.** | | | | | | | | | | | | | | | |
| 1. **Patient Details** | | | | | | | | | | | | | | | |
| **NHS No.** |  | | | | | **Town & Country of Birth** | | | |  | | | | | |
| **Title** |  | | | | |  | | | |  | | | | | |
| **First** **Name** |  | | | | | **Surname** | | | |  | | | | | |
| **Known as** | *(if different from first name)* | | | | | **Date of Birth:** | | | |  | | | | | |
| **Gender** | Male  Female  Indeterminate  Unspecified / Unknown | | | | | | | | | | | | | | |
| **Marital Status**: | Single  Married  Divorced  Co-habiting  Separated  Widowed | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **Ethnicity** | **White** | **Black** | | | | **Asian / Asian British** | | | | | **Chinese & Mixed Background** | | | | |
| British | Caribbean | | | | Indian | | | | | Chinese | | | | |
| Irish | African | | | | Pakistani | | | | | White & Black Caribbean | | | | |
| Other: | | | | | Bangladeshi | | | | | White & Black African | | | | |
|  | | | | | White & Asian | | | | |
|  | | | | | | | | | | | | | | | |
| **Employment**  **Status** | Employed | | | **Occupation:** | | | | | | | | | | | |
| Self-employed | | | | Employed / Paid Carer | | | | Unemployed | | | | Retired | | |
| **Are you a Military Veteran?** | | Yes  No | | | | | **Family Member in Military?** | | | | | | | Yes  No | |
|  | | | | | | | | | | | | | | | |
| **Language** |  | | | | | | **Interpreter Needed** | | | | | | | | Yes  No |
|  | | | | | | | | | | | | | | | |
| **Religion** | C of E | | Buddhist | | | | Sikh | | | | | No religion | | | |
| Catholic | | Hindu | | | | Jewish | | | | | Other: | | | |
| Other Christian | | Muslim | | | | Jehovah’s Witness | | | | |  | | | |
|  | | | | | | | | | | | | | | | |
| **Housing** | Own Home | | Rented Home | | | | | Supported Home | | | | Temporary Housing | | | |
| Homeless | | No Fixed Abode | | | | | In Care | | | | Refugee | | | |
| Other: | |  | | | | | | | | | | | | |
| Live Alone | | Live with Family | | | | | Live with Children | | | | | | | |

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| 1. **Contact Details & Address** | | | | | | **Preferred** |
| **Home Phone** |  | | | | |  |
| **Mobile Phone** |  | | | | |  |
| **Work Phone** |  | | | | |  |
| **E-mail** |  | | | | | |
| **Skype ID** |  | | | | | |
| **Consent** | If you give us a mobile and/or email we will assume you are happy for us to contact you using them. If you are **NOT** happy to be contacted this way please tick the box : | | | | | |
| **Current Address** |  | | | | **Postcode** | |
|  | |
| **Address Type** | Home | Temporary | Correspondence Only | Other: | | |

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| 1. **Family, Relationship & Emergency Contact Details** | | | | | |
| **Next of Kin**  **Name:**  **Relationship:**  **Contact Details:** |  | | **Next of Kin**  **Name:**  **Relationship:**  **Contact Details:** |  | |
| **Names & Ages of Children**  **(if applicable)** | |  | | | |
| **Other individuals in your household (if applicable)** | |  | | | |
| **Emergency Contact/s**  *(name, number & relationship)* | |  | | | |
| **Are you happy for your medical information to be shared with your Next of Kin??**  *(please circle as appropriate)* | | | | | **YES / NO** |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. **Carer Details** | | | | | | | | |
| Do ***you*** have a carer who *you* are **dependent on** for some or all of the time? | | | | | | | Yes  (has a carer)  No | |
| |  |  |  |  | | --- | --- | --- | --- | | **Your Condition** | Physical Disability | Mental Health Problem | Terminal Illness | | Learning Disability | Chronic Disease | Sensory Impairment | | Dementia | Alcohol Misuse | Other: | | Substance Misuse | Elderly | | | | | | | | |  |
| **Name of Person** |  | | **Patient at this practice?** | | | | Yes  No | |
| **Relationship to you** | Child (young carer) | Relative | | | Other: | | | |
| **Type of** Carer | Informal | Paid | | | Parent | Other: | | |
| Carer **Address**  *(if different to yours)* |  | | | | | | | |
| Carer **Home Phone Number** |  | | | Carer **Mobile Phone Number** | | |  | |
| Carer **Email Address** |  | | | **Does the carer hold a care plan for you?** | | | Yes  No | |
| **I am happy for you to share my health care record / information with my carer:** | | | | | | | Yes  No | |
| **Would you like information on support services for carers?** | | | | | | | Yes  No | |

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| Are ***you*** a carer who **looks after someone** else dependent on you for some or all of the time? | | | | Yes  (is a carer)  No |
| **Relationship to you** | Friend  Neighbour  Relative  Other: | | | |
| **Their Condition** | Physical Disability | Mental Health Problem | Terminal Illness | |
| Learning Disability | Chronic Disease | Sensory Impairment | |
| Dementia | Alcohol Misuse | Other: | |
| Substance Misuse | Elderly |
| **Would you like information on support services for carers?** | | | | Yes  No |

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| 1. **Accessible Information Needs** | | | | |
| **Condition / Issue** | Registered  Blind | Registered  Deaf | Other: | |
| **When we speak to you** | British Sign Language | Lip reader | Hearing aid | Other: |
| **When we write to you** | Braille | Large print | Easy read | Other: |
| **Preferred Contact Method** | Telephone | Text message | Post | Other: Email |
| **Other Communication Needs** |  | | | |

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| 1. **Your Medical Information** | | | | | | | | | | | | | | | | | | | | |
| **Height (in metres)** |  | | | | | | | | **Weight (in Kg)** | | | | |  | | | | | | |
| **Alcohol Consumption** | | | | | |  | | | | | | | | | | | | | | |
| How often do you have a drink containing alcohol? | | | | | | Never | | | | Monthly or Less | | | 2-4 times per month | | | | 2-3 times per week | | | 4+ times per week |
| How many units of alcohol do you drink on a typical day when you are drinking? (see below) | | | | | | 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 |
| Image result for alcohol units | | | | | | | | | | | | | | | | | | | | |
| **Smoking Status** | Never  Smoked | | Ex  Smoker | | | | Light Smoker  <10 day | | | | Moderate  Smoker  11-19 a day | | | | | Heavy  Smoker  >20 a day | | | Vaping | |
| **Diet** | Good | | | Average | | | | | | | | Poor | | | | | |  | | |
| **Exercise** | Heavy | | | Moderate | | | | | | | | Light | | | | | | No Exercise | | |
| **Have you ever or are currently suffering from any of the following conditions?** | | | | | | | | | | | | | | | | | | | | |
| Arthritis  Asthma  Autoimmune Disease  COPD  CVA | | Dementia  Depression  Diabetes  Epilepsy  Heart Failure | | | Hypertension  Heart Disorder  Kidney Disease  Liver Disease  Peptic Ulcer Disease | | | | | | | | | | Thyroid Disorder  Stroke  Cancer  - Please specify below: | | | | | |
| Any other relevant past medical history | | | | | | | | Previous operations / surgical procedures | | | | | | | | | | | | |
|  | | | | | | | |  | | | | | | | | | | | | |
| Previous hospital admissions | | | | | | | | Currently being seen at a hospital clinic | | | | | | | | | | | | |
|  | | | | | | | |  | | | | | | | | | | | | |
| Are you allergic to any medications? | | | | | | | | Any other allergies? e.g. animals, dust | | | | | | | | | | | | |
|  | | | | | | | |  | | | | | | | | | | | | |

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| **We use the NHS Electronic Prescription Service (EPS). Please tell us who you would like as your nominated dispenser/pharmacy, then we will send your prescription electronically to them.**  ***Otherwise, when you request a repeat prescription we will send it to Evans Pharmacy on Charles Street in Ruddington to be dispensed. The prescription will be ready to collect in 48 hours.***  **My nominated dispenser/pharmacy, is (Name and Location):** |

**If you are 40-74 we would like to invite you for an NHS Health Check. If you would like one of these please make an appointment with our practice phlebotomist for a fasting blood test and then an appointment one week later for a review and feedback of results with the practice nurse.**

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| **Your Family History** | | | | |
| Please tell us about any important family history of close relatives with medical problems and confirm which relative e.g. Mother, Father , Grandparent or Sibling (brother or sister) | | | | |
| **Condition** (tick all that apply) | **Which relative?** | | **Condition** (tick all that apply) | **Which relative?** |
| Arthritis |  | | Heart Failure |  |
| Asthma |  | | Hypertension |  |
| Autoimmune Disease |  | | Heart Disease |  |
| COPD |  | | Kidney Disease |  |
| Cardiovascular Problem |  | | Liver Disease |  |
| Dementia |  | | Peptic Ulcer Disease |  |
| Depression |  | | Thyroid Disorder |  |
| Diabetes |  | | Stroke |  |
| Epilepsy |  | | Cancer |  |
| **Other relevant family history not listed above:** | | |  | |
| **6a. Women Only** | | | | |
| Do you use any contraception? | | Yes  No  If needed, please book appointment. | | |
| Are you currently pregnant? | | Yes  No  Expected due date: dd / mm /yyyy | | |
| Date of last smear test | | dd / mm /yyyy | | |

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| 1. **Online Access** | | | |
| Online access to your GP record allows you to;   * Renew or order repeat prescriptions, book or cancel appointments online and view your GP record   You can sign up for online services from a tablet or smart phone rather than having to visit or call the practice by using the  **NOTE: To view your GP record you will still need to show ID to the practice** | | |  |
| Would you like to register for online services? | Yes  (Complete section 7a)  No  (Go to section 8) | | |
| **To register in for ONLINE SERVICES, you will need to provide valid photo ID.**  **This will need to be brought in personally so that we can verify the photo ID.** | | | |
| **7a Complete this section only if you wish to have online access** | | | |
| **Please indicate what online services you would like access to (please tick all that apply):** | | | |
| Booking appointments | |  | |
| Requesting repeat prescriptions | |  | |
| Viewing my GP medical record | |  | |
| View coded medical record\*\* –patients aged 16 and over ONLY | |  | |
| View full medical record \*\*. This is a contractual offering for NEW patients registered after April 2019. Retrospective access will NOT be given | |  | |

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| **I wish to access my medical record online and understand and agree with each statement** | |
| I have read and understood the information leaflet **(on page 7)** |  |
| I will be responsible for the security of the information that I see or download |  |
| If I choose to share my information with anyone else, this is at my own risk |  |
| If I suspect that my account has been accessed by someone without my  agreement, I will contact the practice as soon as possible |  |
| If I see information in my record that is not about me or is inaccurate, I will  contact the practice as soon as possible |  |
| If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible. |  |

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| 1. **Record Sharing For Direct Care** | |
| **What is direct care?**  Direct care means that a health worker caring for you wishes to access information held in your GP record that will help them to treat you better. **This data is NEVER used for research purposes or marketing.** | |
| **Local Record Sharing for Direct Care** | |
| Your GP record can be made available to other health care services such as out of hours, emergency services, other GP practices, community services and hospital consultants.  **You will be asked every time by anyone accessing your GP record from outside the practice.** | |
| I am happy to share my GP record to local care services |  |
| I do **NOT** wish to share my GP record to local care services \*  ***(By ticking this box this limits the information we can share with other local health care providers which may compromise the care you may be given)*** |  |

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| **SCR Sharing for Direct Care** | SCR information line: 0300 123 3020 www.nhscarerecords.nhs.uk | |
| The Summary Care Record (SCR) is a national scheme used to support your direct care. The information will be very limited, and includes medication, allergies and adverse drug reactions.  **You will be asked every time by anyone accessing your SCR from outside the practice (unless you cannot give permission).** | | |
| I am happy to have a summary care record created | |  |
| I do **NOT** wish to have a summary care record created  ***(By ticking this box this limits the information we can share with other health care providers such as hospitals, out of hours etc which may compromise the care you may be given)*** | |  |

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| 1. **Association(s) with Medical Practice** | |
| To the best of your knowledge, are any of your relatives or friends currently employed by the Medical Practice? | |
| Yes | No |
| *Staff note: If ‘Yes’ to question above, advise patient of staff records access policy* | |

|  |  |  |  |
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| 1. **Signatures** | | | |
| I confirm that the information I have provided above is true to the best of my knowledge. | | | |
| **Signature** |  | | |
| Signed by patient | Signed on behalf of patient | |
| **Name** |  | **Date** |  |

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| 1. **Checklist** | | |
| Thank you for completing this form. Please check you have completed all sections where possible. | | |
| Please ensure that you bring the following with you to the surgery to complete your registration: | | |
| **1.** | **Completed & Signed GMS1 Form** |  |
| **2.** | **Completed & Signed New Patient Registration Questionnaire** (this form!) |  |
| **3.** | **Photo Proof of ID** - e.g. Passport, Photo Driving License or Photo ID card |  |
| **4.** | If possible, your **Immunisation Records** – usually the Personal Child Health Record (“Red Book”)\*(only for children) |  |
| **5.** | If relevant, your **Repeat Medication Request Slip** from your previous GP |  |
| **6.** | If relevant, your **European Health Insurance Card** |  |

**Thank you for completing this form – please return it to reception**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **For General Practice Use Only** | | | | | | |
| Appointment | Required | | Not Required | |  |  |
| Verified | Mobile Number | | Work Number | | Home Number | Email |
| Photo ID | Passport | | Driving licence | | Identity card | Other |
| Proof of Address | Utility Bill | | Council Tax | | Bank Statement | Other |
| Name of person who authorised and added to system |  | | | | | |
| Online Services Details | | | | | | |
| Date account created: | | | | Date passphrase sent: | | |
| Level of record access enabled | | | | | | |
| Allow appointment booking | | | | Allow completing questionnaires | | |
| Allow viewing summary record | | | | Allow medication requesting | | |
| Record Access | | | | | | |
| Full record | | Full content | | Prospective  content from date dd / mm /yyyy | | |
| Detailed coded record | | Full content | | Prospective  content from date dd / mm /yyyy | | |
| Notes / explanation | | | |  | | |

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| --- |
| ***Key considerations*** |
| ***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 and you cannot contact them. |
| ***Choosing to share your information with someone***  It’s 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. If you require further clarification, please contact the surgery for a clearer explanation. |
| ***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. |

Practices are increasingly enabling patients to be able to request repeat prescriptions and book appointments online.

Some patients may wish to access more information online.

However this requires additional considerations as outlined in this leaflet. You will be asked that you have read and understood this leaflet before consenting and applying to access your records online. The practice will also need to verify your identity.

**Please note:**

* **It will be your responsibility to keep your login details and password safe and secure. If you know or suspect that your record has been accessed by someone that you have not agreed should see it, then you should change your password immediately.**
* **If you can’t do this for some reason, we recommend that you contact the practice so that they can remove online access until you are able to reset your password.**
* **If you print out any information from your record, it is also your responsibility to keep this secure. If you are at all worried about keeping printed copies safe, we recommend that you do not make copies at all.**
* **The practice may not be able to offer online access due to a number of reasons such as concerns that it could cause harm to physical or mental health or where there is reference to third parties. The practice has the right to remove online access to services for anyone that doesn’t use them responsibly.**

**Accessing Medical Records Online**

**Patient Information Leaflet**

**RUDDINGTON MEDICAL CENTRE**