Pelsall Village Surgery

Dr A Amole

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NEW PATIENT QUESTIONAIRE

**All Information provided is confidential.**

We ask you to **FULLY** complete this form to ensure we have accurate details about your health prior to receiving your medical records from your previous GP.

**CHECK LIST**

* Fill in Registration Form, Health Questionnaire and Summary Care Record
* Sign the purple registration form
* If applicable - Supply proof of your medication
* If applicable – Supply a copy of your passport and/or proof of address
* Once Accepted – Allow a further 2 days for you registration to activate
* Book a New Patient Health Check with the Health Care Assistant

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| --- | --- |
| **Surname: Forename:** | **Date of Birth:** |
| **Address:** | **Telephone No(s):****Opt out of Text messaging (tick box) 🞎** |
| **NHS number (If known):** | **Main Language Spoken:** |
| **Email Address: (By providing your email address, you are giving consent to receive emails from the practice)** |
| **Ethnicity:****White/British 🞏 Black/British 🞏 British/Asian 🞎 Mixed British 🞎****Other Ethnic Group 🞎 Please State:**  |

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| **Will you require access to our online appointment / prescription service?** YES/ NO |

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| **Would you like to receive information or would like to join our Patient Participation Group? YES/NO** |
| **Carer:** If you have a carer in place please state name address and telephone number. If you are a carer please state here. |

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| **Medical History:** Please list any serious illness, operations, ongoing problems & disabilities  |
| **Medication:** Please list all regular medication including herbal remedies:**Allergies:**  |

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| Have you ever had a TB vaccination (circle your answer)? YES - Approx When? NO   |
| **Height:** | **Weight:** |

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| **Do you Smoke? YES 🞎 NO 🞎**If yes, would you like help to quit? YES **🞎** |
| **How many units of alcohol do you drink per week?****1 unit = ½ pint of beer/lager/cider,1 small glass of wine, 1 small measure of spirits** |
| **Exercise****Activity Level: Poor 🞎 Moderate 🞎 Fairly Active 🞎 Very Active 🞎** |

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| --- |
| **Family History:** |
| High Blood pressure YES/NO | Glaucoma YES/NO |
| Heart Disease YES/NO | Thrombosis YES/NO |
| Stroke YES/NO | Asthma YES/NO |
| High cholesterol YES/NO | Diabetes YES/NO |
| **Other: (Please state)** |
| **For Women only:** |
| Number of pregnancies |
| Have you ever had a cervical smear? YES / NO If yes date of last smear: |
| Have you ever had an abnormal smear: YES / NO |

**Summary Care Record Patient Consent Form**

Having read the above information regarding your choices, please choose **one** of the options below and return the completed form to your GP Practice:

**Yes – I would like a Summary Care Record**

□ Express consent for medication, allergies and adverse reactions only.

**or**

□ Express consent for medication, allergies, adverse reactions and additional information.

**No – I would not like a Summary Care Record**

□ Express dissent for Summary Care Record (opt out).

Name of Patient: ………………………………………………..…...............................................................

Address: …………………………………………………………………………………………………………………………….

Postcode: ………………………………………… Date of Birth: ………..........................................

NHS Number (if known): …………………………..………………...........................................................

Signature: ………………………………………………………….. Date: ………………………………………………

If you are filling out this form on behalf of another person, please ensure that you fill out their details above; you sign the form above and provide your details below:

Name: …………..........................................................................................................................

**Please circle one:** Parent Legal Guardian Lasting power of attorney

 for health and welfare

If you require any more information, please visit <http://digital.nhs.uk/scr/patients> or phone NHS Digital on 0300 303 5678 or speak to your GP practice

**Dear Patient,**

If you are registered with a GP practice in England you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. You may need to be treated by health and care professionals that do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs.

Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

**You have a choice**

You have the choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care.

Your options are outlined below; please indicate your choice on the form overleaf.

1. **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies and adverse reactions only.
2. **Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies and adverse reactions and further medical information that includes: Your significant illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.
3. **Express dissent for Summary Care Record (opt out).** Select this option, if you **DO NOT** want any information shared with other healthcare professionals involved in your care.

Please note that it is not compulsory for you to complete this consent form. If you choose not to complete this form, a Summary Care Record containing information about your medication, allergies and adverse reactions and additional further medical information will be created for you as described in point b) above.

The sharing of this additional information during the pandemic period will assist healthcare professionals involved in your direct care and has been directed via the Control of Patient Information (COPI) Covid-19 – Notice under Regulation 3(4) of the Health Service Control of Patient Information Regulations 2002.

If you choose to complete the consent form overleaf, please return it to your GP practice.

You are free to change your decision at any time by informing your GP practice.