NEW PATIENT QUESTIONNAIRE

To be completed along with - Family doctor services registration form (GMS1)

Welcome to **The Lakes Medical Practice**. Please complete this form **AND** the family doctor services registration form **(GMS1).** You will also need to bring in two forms of identification, one will need to be photographic (e.g. UK driving licence or passport) and the other a utility bill / statement confirming your home address (dated within the last 3 months).

We also offer Patient Online Access which allows you to order your medication online, book appointments and with some additional checks also have records access. Please complete the online access application form and bring to the surgery with you when you register along with your ID.

Title: Ms, Mrs ,Mr Etc		
Surname/Family Name:		
First Name:		
Middle Name:		
Known as:		
Date of birth:		
NHS Number (if known)		
Gender:		
Ethnicity/Background:		
White		English/Welsh/Scottish/Northern Irish/British
		Irish
		Other, please specify:
Mixed/Multiple ethnic groups		White and Black Caribbean
		White and Black African
		White and Asian
		Other, please specify:
Asian/Asian British		Indian
		Pakistani
		Bangladeshi
		Chinese
		Other, please specify:
Black/ African/Caribbean/Black British		African
		Caribbean
		Any other Black/African/Caribbean background, please describe
Other ethnic group		Arab
		Other, please specify:
Main Language:		
Interpreter Required:	Yes No	
Do you have any communication needs such as braille/large print:	Yes No	

CURRENT Address Details:

House name or Flat number:		
Number & Street		
Town/City		
County:		Postcode:
Access Instructions such as keycode:		

PREVIOUS Address Details, (if recently relocated or moved in the last 5 years):

House name or Flat number:		
Number & Street		
Town/City		
County:		Postcode:

CONTACT DETAILS:

Home Tel Number:	
Mobile Number:	
Private E-mail address:	
I consent to the practice contacting me about my health in the following ways, Please tick **all** that apply	**Home Tel:** ☐ **Mobile Number:** ☐ **E-Mail:** ☐

PREVIOUS GP details:

Previous GP Name:		
Surgery Name:		
Town/City		
County:		Postcode:

NAME(S) OF OTHER FAMILY MEMBERS AT THE SAME ADDRESS TO BE REGISTERED AT THIS PRACTICE:

NAME: ………………………………………… DATE OF BIRTH ………………………………

NAME ………………………………………… DATE OF BIRTH………………………………

NAME: ………………………………………DATE OF BIRTH………………………………..

You will need to complete a separate registration form for each family member. You will be added to our computerised system (EMIS) as connected by household

PERSONAL HISTORY

Have you travelled outside of the UK in the last 2 Years, if so, where?	
Have you ever served in the armed forces, if so when?	
Are you a family member of a current or former member of the armed forces?	If yes, please detail:
Are you housebound:	**Yes** **No**
Do you live in a care/nursing or residential home:	If yes, please detail:
Are you registered as disabled?	If yes, please detail:
Do you have a Carer?	**Yes** (Please complete below) **No**
If Yes please provide name and contact details of carer or care company	
Are you a carer, including young carers?	**Yes** **No**
Do you have social worker? If Yes please provide name and contact details of social worker	
Are there any other health professionals involved your care, if yes please give details:	

Contact in case of emergency/Next of kin: This is the person who would be contacted incase of an emergency	**Name:** **Address:** **Relationship:** **Contact Telephone Number:**

MEDICAL DETAILS

Do you have any known allergies, if yes please state:	
Details of any Chronic or serious illnesses, operations or disabilities:	
Please give details of any current medications or contraceptive pills you take	
Have you ever refused treatment/screening of any kind, if so, please detail:	

FEMALE PATIENTS

Date of last cervical smear, if known	
Date of last mammogram, if known	
MMR status (Measles, Mumps, Rubella) If known	
If you have children, what years were they born?	
Do you have a contraceptive implant or coil fitted, please specify	
Do you use any other form of contraception, please specify	

FAMILY MEDICAL HISTORY

	Which Relation?		Which Relation?
Heart attack	Age:	Glaucoma	
Diabetes		Asthma	
High Blood Pressure		Eczema	
Cancer		Migraine	
Stroke	Age:	Epilepsy	
Mental Illness		Arthritis	
Tuberculosis		Anaemia	

SMOKING HISTORY

Do you currently smoke? **YES** **NO**

How many cigars / cigarettes / ounces of tobacco smoked per day?

Have you ever smoked? **YES - when did you give up ………….?**
NO

ALCOHOL CONSUMPTION

How many units of alcohol do you have in a week on average? ………………………. Units

ORGAN DONATION

From spring 2020, organ donation in England will move to an 'opt out' system. You may also hear it referred to as 'Max and Keira's Law'.

This means that all adults in England will be considered to have agreed to be an organ donor when they die unless they have recorded a decision not to donate or are in one of the excluded groups.

You still have a choice if you want to be an organ donor or not when you die.
Please make sure you have recorded your consent or dissent on the GMS1 form.
If consent is given please sign the appropriate section, and please make sure that you make your loved ones aware of your choice.

Do you hold the following documentation? – The documents listed below are regarding your personal wishes in respect of any future medical treatment, if YES, please bring forms into the practice so that they can be recorded correctly onto our medical record. We cannot add details onto the medical record without formal documentation.

DNA/CPR (Do not resuscitate) Please circle:	YES	NO
Advanced Directive/Living Will	YES	NO
Lasting Power of Attorney (Health & Welfare)	YES	NO

Consent for family member, carer or friend to be added (Section must be signed):

Would you like a family member, friend or carer to be able to discuss medical details on your behalf? Due to patient confidentiality we need your permission to do this so we can record consent onto your records. Please tick which option you require:

YES – Full access to any records information and ability to book/cancel appointments ☐

YES – Limited access to book appointments and order medications only ☐

YES – Limited access to book appointments only ☐

If yes what is their name? .... Relationship to you….. ....

PATIENT SIGNATURE: …………………………………………………

Please be aware that this permission will be logged and kept on file until such as time that we receive your written instruction to remove the above named person.

Do you agree to our text messaging service? This would be used for health related reasons such as results/appointments or to ask you to contact the practice.	**Yes** **No**	☐ ☐

Summary care Record information and opt in/out:

The NHS Summary Care Record (SCR) is an electronic summary of key clinical information (including medicines, allergies and adverse reactions) about a patient, sourced from the GP record. It is used by authorised healthcare professionals, with the patient's consent, to support their care and treatment.

What does it mean if I DO NOT have a Summary Care Record? NHS healthcare staff caring for you may not be aware of your current medications, allergies you suffer from and any bad reactions to medicines you have had, in order to treat you safely in an emergency

Summary Care Record Options:

YES ☐ I would like a Summary Care Record containing details of my medications, allergies and any bad reactions to medications I have had AND any other information that I have agreed with my GP Practice to have included in my Summary Care Records

NO, I wish to opt out and understand what this means ☐

Please note: If you do not tick a preference, by signing this form, you will be consenting to a summary care record being created. If you wish to opt out please notify the practice and request an opt out form.

National Data Opt-Out Service information:

The national data opt-out, introduced on 25 May 2018, provides a secure and accessible way for patients to opt out of their confidential patient information being used for purposes other than their individual care and treatment except for certain exemptions

If you are happy about how your confidential patient information is used you do not have to do anything else.

If you do not want your confidential patient information to be used for planning and looking into new treatments you can:

View or change your national data opt-out choice at any time by using the online service at:

www.nhs.uk/your-nhs-data-matters or by calling 0300 3035678.

This is not something that can be changed or altered at the practice.

I have read and understood all of the information made available to me both via the practice website and leaflet, including information relating as to how my information will be used/stored. I request to become a registered patient at The lakes Medical Practice, Penrith

PATIENT SIGNATURE..Date........................

OFFICE USE ONLY:

Date received:	ID checked by:	Input by:	Coding complete:	Scanned by: