# The Limes Medical Centre
# New Patient Health Questionnaire

Thank you for applying to join The Limes Medical Centre. As a new patient to the practice, we would like to ask you to complete the following questionnaire. This will assist in providing you with the best care. You must sign the form on the final page to confirm all the details given are correct. **All information given to us will be confidential and used only in accordance with statutory regulations, e.g. Data Protection Act/GPDR.**

UK residents and those residing in the UK for legal and settled purpose AND living within the practice area, are entitled to register with us. We reserve the right to remove patients who do not live within our practice boundary. All patients found not to be living in the practice area will be removed from our list with 28 days notice. UK citizens who now live abroad for most of the year may not be entitled to free NHS care. European Economic Area (EEA) rules apply for those residing in a member state. **If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.**

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

Please complete all areas that are applicable to you or your child in **CAPITAL LETTERS** and tick the appropriate boxes.

| | |
|---|---|
| Full Name | Mr/Mrs/Miss/Ms/Dr<br>Master/Mx/Other: |
| Current Address<br><br>Postcode | Date of Birth |
| Contact Telephone Number(s) | Previous Address<br><br>Postcode |
| NHS Number | Email Address |
| Occupation | Previous GP Surgery |
| If not born in the UK, date of first entry to the UK<br><br>*N.B. Copy of Passport will be required to register* | Religion / Gender |
| | **Are you a Military Veteran?** ☐ Yes ☐ No<br>Enlistment Date:<br>Service/Personnel Number: |

*Main spoken languages

☐ **English**

☐ **Other** (please specify)

Interpreter required?

☐ Yes ☐ No

*What is your ethnic group? (please circle the option that best describe your ethnic group or background)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **White** | English | Welsh | Scottish | N Irish | British | Irish | Irish Traveller |
| **Mixed** | White & Black Caribbean | White & Black African | White & Asian | | | | |
| **Asian** | Indian | Pakistani | Bangladeshi | Chinese | | | |
| **Black** | Caribbean | African | | | | | |
| **Other** *Please specify*: | | | | | | | |

**Electronic Prescription Service (EPS)**

All prescriptions will now be sent electronically. Please nominate a pharmacy:

☐ Peak Pharmacy ☐ Enderby Pharmacy ☐ Village Pharmacy ☐ Cosby Pharmacy ☐ Whetstone Chemist

☐ Other (please specify)

**Do you have a Carer?** ☐ Yes ☐ No

If yes, what is their name and contact number?

| Name of next of kin | Relationship to you/child |
|---|---|
| Next of kin telephone number(s) | Next of kin address (if different to above) |

Are you a Carer? ☐ Yes ☐ No
If yes, do you look after someone who is a patient of The Limes Medical Centre? ☐ Yes ☐ No
If yes, what is their name?
If No, please give the name of the GP surgery who treats the person you care for:
What is your relationship to them?
Approximately how much time per week do you spend as a carer?

Are you an Adult with social care involvement?
☐ Yes ☐ No
If yes, please state the reason why

| Do you have a nominated patient advocate/advocacy service or Lasting Power of Attorney?<br>☐ Yes ☐ No<br>Details | If you wish to add a representative to access your medical records or speak to us on your behalf, you will need to complete a consent form. This can be sent to you via:<br>Text ☐ Post ☐ |
|---|---|

Would you like to receive text reminders for appointments? Yes ☐ No ☐

I consent to the practice contacting me by text message for the purposes of health promotion, practice news and appointment reminders. I acknowledge that the appointment reminders by text are an additional service and that they may not be sent on all occasions. The responsibility for attending appointments and cancelling them still rests with me.
**I agree to advise the practice if my mobile number changes or if it is no longer in my possession.**

**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 you wish to OPT-IN to the SCR** ☐

**National Data Opt-out**

Due to the introduction of the General Data Protection Regulation (GDPR) in May 2018 there have been national changes on how patients record their preference as to how they would like their data shared.

**More information can be found by visiting the NHS website** https://www.nhs.uk/your-nhs-data-matters/ . You can update your preferences there.

**Specific Needs**
Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:

| | |
|---|---|
| **Please state any Sensory Impairment you have:** | (i.e. Speech, Hearing, Sight) |
| **Please state any Physical disabilities you have:** | |
| **Please state any Mental disabilities you have:** | |
| **Please state any Religious or Cultural needs:** | |

**Are you an 'Assistance Dog' User?** ☐ Yes ☐ No

**Domestic Abuse**
If domestic abuse is affecting your health, you can speak to someone here. Please tick this box if you would like a GP to contact you. ☐

## Medical details

| | |
|---|---|
| Height m cm | Do you have any current health problems, please include dates? *( Asthma, COPD, Diabetes, Heart Disease, Learning disabilities, mental health problems )* |
| Weight kg | |
| If over 18 please provide recent BP reading:<br><br>*If you do not have a monitor, a BP reading can be taken on our self service machine in our 'On The Day' Reception.* | Are you taking any medication? ☐ Yes ☐ No<br><br>Please provide repeat prescription or list of medication from previous practice |

Are you allergic to any medicine or other substance? ☐ NO ☐ YES - please list below

| Family History | | | |
|---|---|---|---|
| *Only tick if these apply to first degree relatives.*<br>*i.e parents and siblings.* | Asthma ☐ | Diabetes ☐ | Heart disease ☐ |
| | High Blood Pressure ☐ | Stroke/Mini Stroke ☐ | Skin conditions ☐ |
| | Depression ☐ | Peptic ulceration ☐ | Thyroid Disorder ☐ |
| | Eyesight problems ☐ | Asthma/COPD ☐ | Cancer ☐ |

* What are your smoking habits? ☐ Smoker ☐ Ex-Smoker ☐ Never Smoked
How many do you smoke a day? _____
Would you like advice on quitting?
☐ Yes ☐ No

| **Alcohol Users Disorders Identification Test (AUDIT)** | **0** | **1** | **2** | **3** | **4** |
|---|---|---|---|---|---|
| How often do you have a drink containing alcohol? | Never | Monthly or less | 2-4 times a month | 2-3 times a week | 4 or more times a week |
| How many drinks containing alcohol do you have on a typical day when you are drinking? | 1 or 2 | 3 or 4 | 5 or 6 | 7 to 9 | 10 or more |
| How often do you have six or more drinks on one occasion? | 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 have you failed to do what was normally expected of you because of drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| How often during the last year have you needed a first 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 of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| Have you or someone else been injured because of your drinking? | No | | Yes, but not in the last year. | | Yes, during the last year. |
| Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down? | No | | Yes, but not in the last year. | | Yes, during the last year. |

**Immunisations**
If you are from abroad please give a copy of your immunisations.
If a child - are they up to date with their immunisations? ☐ Yes ☐ No (if no please specify)

**If Registering a Child please complete the following:**

| Who has the parental or legal responsibility for the child? | If you are the parent/guardian/foster carer /kinship carer **but cannot** consent please detail below who can |
|---|---|
| ☐ You as the legal parent/guardian/adoptive parent<br><br>☐ **Other** (please specify) _____<br><br>Name: _____<br><br>Contact Number:<br>Evidence of parental responsibility<br>(birth certificate/social care information) : | Name: _____<br><br>Relationship to child:_____<br><br>Contact Number: |

| Name of school or nursery: | Home schooled ☐ |
|---|---|
| Does the child have a social worker?<br>☐ **Yes** ☐ **No** | Name of Social Worker: |
| Are there any other Agencies involved in their care? ☐ **Yes** ☐ **No**<br>**Contact Details:** | |

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

If a child, are they looked after? ☐ Yes ☐ No
If Yes, under what arrangements:
☐ Section 20-Voluntary Care ☐ Subject to an Interim Care Order ☐ Subject to a Full Care Order
☐ Placed for adoption ☐ Unaccompanied Asylum Seeker

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

***What is Private Fostering?***
A private fostering arrangement is one that is made without the involvement of the Local Authority to look after a child under the age of 16 (or under 18 if disabled) by someone other than a parent or close relative, for 28 days or more and can include those living with extended family members. So, this could be a child living with people as stated below:

| *Private Fostering **includes** a child living with:* | *Private Fostering **does not include** a child living with:* |
|---|---|
| • godparents<br>• great-grandparents<br>• great aunts or uncles<br>• family friends<br>• stepparents where a couple isn't married or in a civil partnership.<br>• cousins<br>• a host family which is caring for a child from overseas while they are in education here. | • brothers or sisters<br>• grandparents<br>• aunts or uncles<br>• stepparents where a couple is married or in a civil partnership.<br>• mother or father<br>• children and young people who are being looked after by the Local Authority |

## 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.

**TO ENABLE US TO REGISTER YOU FOR ONLINE SERVICES, PLEASE BRING PHOTO ID TO RECEPTION.**

**Application for online access to my medical record**

I wish to access my medical record online and understand and agree with each statement (please tick)

| | |
|---|---|
| 1. I will be responsible for the security of the information that I see or download | ☐ |
| 2. If I choose to share my information with anyone else, this is at my own risk | ☐ |
| 3. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement | ☐ |
| 4. If I see information in my record that is not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible | ☐ |

**On-line account**

| | |
|---|---|
| I wish to have access to the following online service (tick all that apply) | |
| 1. Booking appointments | ☐ |
| 2. Requesting repeat prescriptions | ☐ |
| 3. Accessing my medical records | ☐ |

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

**If signed for on behalf of patient** (*if applicable*)
(Minors under 16 years old or adults lacking capacity)

**Full Name:**

**Relationship:**

**Thank you for providing this information, registration can take up to 2 weeks (providing this form has been completed fully).**

**We look forward to providing you with a high standard of care in a friendly and professional manner.**