Southernhay House Surgery

New Patient Registration Document

Welcome to Southernhay House Surgery

New Patient Registration Questionnaire

Please ensure that you fill out **all** of the following information

Personal Information

- Have you ever been registered with Southernhay House Surgery?

Yes **No**

Title	Forename(s)	Surname
Previous Surname	Gender: (please circle) Male Female	
Current Address: Post Code:		
Date of Birth:	NHS Number:	
Home Tel Number:	Mobile Number:	
Place of Birth:	Marital Status:	
Occupation:	Religion:	
Previous GP and Practice:	Your Previous Address:	

Next of Kin

Name:	Contact Number:
Relationship to You:	

Registering With a NHS GP Practice

Have you been registered with an NHS GP Practice before? **Yes** **No**

If you have answered **NO** – please complete the boxes below

Have you just returned to the UK after living abroad?	**Yes** **No**
If YES what date did you leave the UK?	
What date did you return to the UK?	

Where you born outside of the UK?	**Yes** **No**
If YES what date did you first come to the UK?	

Ex-Services

Are you Ex-Services? **Yes** **No**

If YES please enter your dates of enlistment (From-To)

Ethnicity and Language

The NHS requires all medical records to show a patient's ethnic origin

Please tick your ethnic group

White: British or Mixed British		Asian: Pakistani or British Pakistani	
White: Irish		Asian: Bangladeshi or British Bangladeshi	
White: Any other background		Black: Caribbean	
Mixed: White and Black Caribbean		Black: African	
Mixed: White and Black African		Black: Any other background	
Mixed: White and Asian		Chinese	
Mixed: Any other background		Any other ethnic group (please specify)	
Asian: Indian or British Indian			

If you **need a translator**, please inform us of the language you require: _____

Clinical Information

Family Medical History

Do any of the following illnesses run in your family? Please tick as appropriate:

Diabetes		Angina	
Asthma		Osteoporosis	
High Blood Pressure		Other Hereditary Disease (please specify type)	
Stroke		Heart Disease	
High Cholesterol		Cancer (please specify type)	
Epilepsy			

Personal Medical History

Do you / have you ever suffered with any of the following illnesses? Please tick as appropriate:

Diabetes Type I Type II		Angina	
Asthma If YES have you used inhalers in the last 12 months?			
High Blood Pressure		Other Hereditary Disease (please specify)	
Stroke		Heart Disease	
High Cholesterol		Cancer (please specify type)	
Epilepsy		Osteoporosis	

HAVE YOU EVER HAD ANY OTHER ILLNESSES, ACCIDENTS, HOSPITAL ADDMISSIONS, INVESTIGATIONS OR OPERATIONS? (please circle and specify below)

Yes **No**

Date:

Date:

Date :

Are you a Wheelchair User or unable to climb the stairs? YES/NO (If yes we will put a note on your record to ensure all of your appointments are on the ground floor)

Mental Health

Do you have a history of any of the following mental health issues?

Please circle as appropriate:

Anxiety	Yes No	If YES Date Diagnosed:
Depression	Yes No	If YES Date Diagnosed:
OCD	Yes No	If Yes Date Diagnosed:
Bipolar Disorder	Yes No	If Yes Date Diagnosed:
Personality Disorder	Yes No	If Yes Date Diagnosed:
Psychotic Disorder	Yes No	If Yes Date Diagnosed:
Other Mental Health Issue (please specify)		

FOR FEMALES ONLY

Are you currently using a form of contraception? Please specify:	
If you do use contraception when was your last check-up / review with a GP or Nurse?	Date:
If you have a coil or implant approximately what date was it fitted?	Date:
If you have depot injections when was your last one?	Date:
Have you had a recent smear?	Date:
Have you had a Hysterectomy?	Date:

Allergies

Do you have any severe allergies? **No / Yes (please list below)**

1.	3.
2.	4.

Medication

Are you taking any regular medication? **Yes** **No**

If YES please specify which medications you take on a regular basis below. It would be very helpful if you had the repeat medication slip from one of your old prescriptions.

Medication	**Dose**	**How many times daily**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Pharmacies

If you do require repeat prescriptions, and you would like to collect your prescription directly from a pharmacy rather than the surgery, please specify below which pharmacy you would like your prescription sent to. Please note that **ONLY** the pharmacies specified are able to provide this service for our surgery.

Sainsburys	Guildhall		**Day Lewis**	Summer Lane	
	Pinhoe			Beacon Lane	
Lloyds	Heavitree		**Well Pharmacy**		
	Magdalen Road		**St Leonards**		
	Sidwell Street		**Tesco**		
Boots	High Street		**Superdrug**		
	Exe Bridges		**Pinhoe Pharmacy**		

Lifestyle

Exercise

Please circle which of these terms best describes how much exercise you take on a regular basis

None	Light	Moderate	Heavy

Body Measurements

Height	
Weight	
BMI	**For Admin Use Only**

Smoking Status

Please tick boxes as appropriate

Never Smoked			
Ex-Smoker		Date Stopped?	
Cigarette Smoker		How many per day?	
Roll Own Cigarettes		How many per day?	
Cigar Smoke		How many per day?	
Pipe Smoker		How many grams per day?	

If you answered YES to being a smoker would you like help giving up? **Yes** **No**

If you answered YES please call 01884 836024 for further information.

Alcohol Consumption

Each of the above = 1 unit of alcohol

How many units of alcohol do you drink per week?	Units:

Please now complete the Alcohol Questionnaire

Alcohol FAST Questionnaire

Questions	Scoring system					Your score
	0	1	2	3	4	
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	
Only answer the following questions if the answer above is Never (0), Monthly (1) or Less than monthly (2). Stop here if the answer is Weekly (3) or Daily (4).						
How often during the last year have 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 been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring:

If score is 0, 1 or 2 on the first question then continue with the next three questions.
If score is 3 or 4 on the first question – stop here. This indicates FAST positive.

An overall total score of 3 or more (on the first question or all four questions) is FAST positive.

What to do next?

If **FAST positive**, **complete** remaining **AUDIT** questions **over the page**

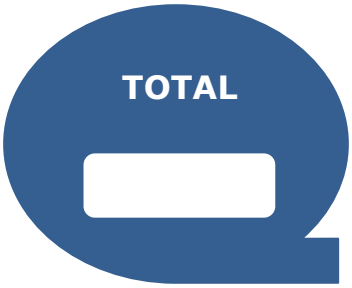
Remaining Alcohol AUDIT questions

Questions	Scoring system					Your score
	0	1	2	3	4	
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 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 that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence

Would you like any help reducing your alcohol consumption? If yes, please book an appointment to see a GP.

TOTAL Score equals
FAST Score (opposite) +
Score of remaining questions



Are You A Carer?

A carer is someone of any age who provides unpaid support to family or friends who could not manage without this help.

If Yes who are you are carer for?

Name:			
Relationship to you?	Address: Postcode:		
Home Number:	Mobile:		
Is the person you care for registered at Southernhay House Surgery?		**Yes**	**No**

Would you like to be included in our carers register? **Yes** **No**

Would you like your information passed to SOUTHELP our carers group? **Yes** **No**

Do You Have A Carer?

If YES please provide details below.

Name:			
Relationship to you?	Address: Postcode:		
Home Number:	Mobile:		
Is the person who cares for you registered at Southernhay House Surgery?		**Yes**	**No**

Text Messaging and Email Consent

Southernhay House Surgery offers a text messaging and email service for information that is relevant to your on-going healthcare e.g. appointment reminders.

Please **circle** one of the following:

I consent to receiving text messages/emails from Southernhay House Surgery?	**Yes**	**No**
My Email Address is:		

I understand that it is my responsibility to inform Southernhay House Surgery should my phone number or email address change or if it has been lost/stolen.

Signed: **Date:**

Southernhay House Surgery

Patient Application for Online Access to My Medical Record

Surname	Date of birth
First name	
Address Postcode	
Email address *	
Telephone number	Mobile number

*Please note including your email address gives us consent to use it.

I wish to have access to the following online services (please tick all that apply):

1. Booking appointments	
2. Requesting repeat prescriptions	
3. Accessing my medical record	

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

I have read and understood the information leaflet provided by the Practice	
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	
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.	

Signature	**Date**

For Practice use only

Patient NHS number		Practice computer ID number	
Identity verified by (initials)	Date	Method Vouching □ Vouching with information in record □ Photo ID and proof of residence □	
Authorised by		Date	
Date account created			
Date login details provided			
Level of record access enabled All Prospective Retrospective Detailed coded record Limited parts		Notes / explanation	

Your Name:

Date of Birth:

NHS Number (if known):

Southernhay House Surgery offers its patients the choice of having a Summary Care Record.

The new NHS Summary Care Record has been introduced to help deliver better and safer care and give you more choice about who you share your healthcare information with.

What is the NHS Summary Care Record?

The Summary Care Record contains basic information about:

- **any allergies you may have,**
- **unexpected reactions to medications, and**
- **any prescriptions you have recently received**.

The intention is to help clinicians in A & E Departments and 'Out of Hours' health services to give you safe, timely and effective treatment. Clinicians will only be allowed to access your record if they are authorised to do so and, even then, only if you give your express permission. You will be asked if healthcare staff can look at your Summary Care Record every time they need to, unless it is an emergency, for instance if you are unconscious. You can refuse if you think access is unnecessary.

Over time, health professionals treating you may add details about any health problems and summaries of your care. Every time further information is added to your record, you will be asked if you agree (explicit consent).

Children under the age of 16

Patients under 16 years will not receive this form, but will have a Summary Care Record created for them unless their GP surgery is advised otherwise. **If you are the parent or guardian of a child then please either make this information available to them or decide and act on their behalf. Ask the surgery for additional forms if you want to opt them out.**

- If you are **happy** for a Summary Care Record to be set up for you then you need **take no further action.**
- If you want to **opt-out** now please **tick the box below and sign** and return it to Reception as soon as possible.

Please tick the box and sign below if you do not want a Summary Care Record:

No I do not want a Summary Care Record ☐

Signed: _____ Date: _____

Hand this form in at your Surgery if you wish to Opt-Out

Southernhay House Surgery

ACCESSIBLE INFORMATION NEEDS QUESTIONNAIRE

We wish to understand and record any particular communication needs you might have. We will then do our best to meet your needs in all contacts with the Practice.

Name ……

Date of birth ……

Completed by patient / guardian / carer

Date completed …….

1. **Is your communication with others affected by a health problem or disability which has lasted, or is expected to last, at least 12 months?**

   YES / NO

   If YES please complete the rest of the questionnaire

   If NO you don't need to answer any other questions

2. **What health problem or disability do you have?**

   …….

   …….

   What is the best way for us to send you information?

   …….

   …….

3. **Do you need written information in a format other than standard print?**

   …….

   …….

4. **What communication support could we provide for you at appointments?**

   …….

   …….

5. **Can we share this information with other health and social care providers?**

   YES / NO