The Hawthorns Surgery

.Date…….

NEW PATIENT REQUEST TO JOIN PRACTICE LIST

Please complete and return this questionnaire together with **2** forms of identification.

- Passport *or* photo driving licence *or* National Identity card

And

- Bank/ building society statement *or* utility bill (less than 3 months old) showing home address
- **ID Verified by…….(Office use only)**
- **Date of NP Screening appointment:…../……/…… (Office use only)**
- **Your nominated/allocated GP is your registered GP**

Patient Details:

MR ☐ MRS ☐ MS ☐MISS ☐ MALE ☐ FEMALE ☐ Marital Status…… ……..

SURNAME: …….. Previous Surnames:……

FORENAMES: ……. ……. …… DOB: …../……../……. *For children aged 5 yrs and under please supply vaccination details below, & parent details we will pass page 1 to our health visiting team. Patients aged 75 and over are entitled to a free health check.*

Parent Details Mothers Name……..Fathers name…….

NHS NUMBER:……Place of Birth……

CURRENT ADDRESS:

……

……**Post code**…….

PLACE OF BIRTH:……

HOME PHONE NUMBER: …… MOBILE NUMBER:……

*We sometimes contact our patients via text message please tick this box if you do **NOT** want to be contacted by text message* ☐

WORK NUMBER: …… EMAIL ADDRESS:……..

NAME OF CHILDS SCHOOL (*if applicable*)……..

Important - please help us trace your previous medical records by providing the following information:

PREVIOUS ADDRESS IN UK: ……

PREVIOUS DOCTOR: ……

SURGERY ADDRESS:……

If you are from abroad:

FIRST UK ADDRESS WHERE REGISTERED WITH A GP: ……

IF PREVIOUSLY RESIDENT IN UK, DATE OF LEAVING: ……

DATE YOU FIRST CAME TO LIVE IN UK:……..

Details of any last adult vaccinations: When was your last Tetanus, Flu jab, Pneumococcal jab, Shingles vaccine?

……

Any Travel Vaccinations? List with dates if possible…….

……..

Details of routine childhood vaccinations (aged 5yrs and under) you may prefer to supply a copy of their 'red book' personal child health record.

……

Ethnic Status

WHITE		**BLACK OR BLACK BRITISH**		**OTHER ETHNIC GROUPS**	
British	☐	Caribbean	☐	Chinese	☐
Irish	☐	African	☐	Any other ethnic group	☐
Any other white background	☐	Any other black background	☐		
MIXED		**ASIAN OR ASIAN BRITISH**		**FIRST LANGUAGE**	
White & Black Caribbean	☐	Indian	☐	English	☐
White & Black African	☐	Pakistani	☐	Other Please state	
White & Asian	☐	Bangladeshi	☐		
Any other mixed background	☐	Any other Asian background	☐		

If you are returning from the Armed Forces:

ADDRESS BEFORE ENLISTING:……

SERVICE OR PERSONAL NUMBER:……

ENLISTMENT DATE: ……. DISCHARGE DATE: ……..

NHS Organ Donor Registration

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death.

(Please tick as appropriate)

☐Kidneys ☐Heart ☐Liver ☐Corneas ☐Lungs ☐Pancreas ☐Any part of my body

Signature confirming consent to organ donation:……Date …….

NHS Blood Donor Registration

I would like to join the NHS blood donor register as someone who may be contacted and be prepared to donate blood.

Signature confirming consent to inclusion on the blood donor register:……Date …….

Have you given blood in the last 3 years? **YES** / **NO**

HEALTH QUESTIONS

1	**What is your smoking history?** *If you are interested in giving up smoking, you can book an appointment at reception for free and confidential support from experienced advisors.*	Never smoked ☐ Ex-smoker ☐ Current smoker ☐
2	**What is your Height? (Feet or metres)……..Weight (stones or kg)…….**	
3	**Are you a main carer for anyone or does someone care for you?** *A carer, without being paid, provides help and support to a friend, neighbour or relative who could not manage otherwise because of frailty, illness or disability, if yes please ask for a carers information pack and a carers form at reception.*	Yes ☐ No ☐
4	**Women aged 25 - 65 yrs** When did you have your last cervical smear	
5	**Women aged 50 – 64** When did you last have your breast screening	
6	Have you had a hysterectomy? If yes give date	
7	Do you have a coil fitted? If yes give date	
8	**Next Of Kin** – separate form available from reception if you wish us to record a NOK for data protection and confidentiality purposes	

Please name any drug or medication taken regularly (including ''the pill'') but note you will need to **book an appointment with the GP for your first prescription, please advise us of details if you currently have a nominated pharmacy who deal with your prescription requests.**

……

……

Are you allergic to anything? Please give details (especially drug allergies)……

Family History

Has any close family member (grandparent, parent, brother, sister, aunt or uncle) had any of, or suffer from, any of the following?

Problem	Their Relationship to You	Their Age When Illness Started
Heart Attack		
Angina		
Stroke		
Asthma		
Diabetes		
Cancer (*state type e.g. bowel, breast)*		

PERSONAL HISTORY

Your full medical record will be sent to us from your last practice in due course. However, in the meantime it is important that we know about the following:

1	Are you diabetic?	Yes/ No
2	Have you ever had a heart attack?	Yes/ No
3	Have you ever had angina?	Yes/ No
4	Have you ever had a Stroke or Transient Ischaemic Attack (TIA) sometimes called a 'mini-stroke?	Yes/ No
5	Do you take medication for an under-active thyroid gland (Hypothyroidism)?	Yes/ No
6	Are you on treatment for blood pressure (Hypertension)?	Yes/ No
7	Do you have Chronic Obstructive Pulmonary Disease (COPD)? This is a disease requiring regular use of inhalers but is not asthma.	Yes/ No
8	Do you take medication for epilepsy?	Yes/ No
9	Do you have asthma?	Yes/ No
10	Have you recently been diagnosed with cancer or any other serious or life threatening disease not mentioned above?	Yes/ No

On Line services

Did you know?

You can book appointments and order repeat medication on line

Application forms available at reception or on our website via the online services tab.

If you wish to view a summary of your medical records on line please complete an application form available at reception or on our website via the online services tab
(Currently only therapy, allergies & contraindications available to view)

You can collect your token from the surgery after 5 working days.

Summary Care Record

How we use your data:

A Summary Care Record is an electronic record which contains information about the medicines you take, allergies you suffer from and any bad reactions to medicines you have had. Having this information stored in one place makes it easier for healthcare staff to treat you in an emergency, or when your GP practice is closed. If you are happy for us to make a Summary Care Record for you please tick the **Yes** box. If you do not want us to make a Summary Care Record for you, please tick **No** – further information on what this means to you can be found at www.nhscarerecords.nhs.uk or by phoning 0300 123 3020 where you can find information in other formats and languages.

This part of the application form must be completed or it will delay your registration.

☐ **Yes** ☐ **No**

SIGNATURE OF PATIENT: …… ……..

SIGNATURE ON BEHALF OF PATIENT:……**PRINT NAME**:……

Alcohol Screen – Please complete for each patient over 18yrs of age registering.

Name:……

Please circle/tick the answer that is correct for you.
These questions ask about the alcohol you have drunk in the last 6 months. The questions ask about how many standard drinks you have consumed. Please note that 1 standard drink = 1 unit of alcohol. So, for example, a pint of regular beer or lager is equal to 2 standard drinks or 2 units.

1. How often do you have a drink containing alcohol?				
Never	Monthly or less	Two to four times a month	Two to three times per week	Four or more times per week
2. 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
3. How often do you have six or more drinks on one occasion?				
Never	Less than monthly	Monthly	Two to three times per week	Four or more times per week
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	Two to three times per week	Four or more times per week
5. How often during the last year have you failed to do what was normally expected from you because of drinking?				
Never	Less than monthly	Monthly	Two to three times per week	Four or more times per week
6. 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	Two to three times per week	Four or more times per week
7. How often during the last year have you had a feeling of guilt or remorse after drinking?				
Never	Less than monthly	Monthly	Two to three times per week	Four or more times per week
8. 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	Two to three times per week	Four or more times per week
9. Have you or someone else been injured as a result of your drinking?				
No	Yes, but not in the last year		Yes, during the last year	
10. Has a relative or friend, or a doctor or other health worker, been concerned about your drinking or suggested you cut down?				
No	Yes, but not in the last year		Yes, during the last year	

The Accessible Information Standard aims to ensure that patients (or their carers) who have a disability or sensory loss can receive, access and understand information, for example in large print, braille or via email, and professional communication support if they need it, for example from a British Sign Language interpreter.

This applies to patients and their carers who have information and / or communication needs relating to a disability, impairment or sensory loss. It also applies to parents and carers of patients who have such information and / or communication needs, where appropriate. Individuals most likely to be affected by the Standard include people who are blind or deaf, who have some hearing and / or visual loss, people who are deaf blind and people with a learning disability. However, this list is not exhaustive.

• Do you have communication needs? Yes No

• Do you need a format other than standard print? Yes No

• Do you have any special communication requirements? Yes No

If Yes

• What is your preferred method of communication? ……

• How would you like us to communicate with you? ……

• Can you explain what support would be helpful? ……

• What is the best way to send you information? ……..

• What communication support could we provide for you? ……

……

Name: ……. Date of birth: …….

If you have a carer do they need communication assistance? Yes € No €

If 'Yes' what is your Main Carer's name: ……..
Do you consent to the practice contacting your
main carer regarding your care? Yes € No €

What is the best way to contact them?.....