ID seen (type)

Proof of address (type)

**Buxted, East Hoathly & Manor Oak Surgeries**

NEW PATIENT HEALTH CHECK QUESTIONNAIRE

Date

|  |  |
| --- | --- |
| **NAME:** | Address: |
| Date of Birth: |
| Home telephone no:  Mobile no: |
| Name of next of kin:  Phone no:  Relationship to you: | e-mail address: |
| Nominated Pharmacy for Electronic Prescribing Service: |
| Ethnicity: | First language: |
| Height: | Weight: |
| Occupation: | |
| Are you anyone’s carer?  If so, whose? | |

Have you had any of the problems listed below? Please give more details where the answer is yes

|  |  |  |  |
| --- | --- | --- | --- |
| **PROBLEMS** | **√ if yes** | **Year** | **More details** |
| High Blood pressure |  |  |  |
| Stroke or ‘TIA’ |  |  |  |
| Heart Attack |  |  |  |
| Angina |  |  |  |
| Heart surgery or Angioplasty |  |  |  |
| DVT or Pulmonary Embolism |  |  |  |
| Diabetes |  |  |  |
| Thyroid problems |  |  |  |
| Liver disease or Splenectomy |  |  |  |
| Kidney disease |  |  |  |
| Asthma |  |  |  |
| Chronic Lung disease |  |  |  |
| Cancer (more details please) |  |  |  |
| Other Operations or Accidents |  |  |  |
| Psychiatric or Emotional problems |  |  |  |
| Allergies (more details please) |  |  |  |
| Other problems for which you need to see a hospital specialist (more details please) |  |  |  |

**Do you have any information or communication support needs relating to a disability, impairment or sensory loss?** Yes/No

**If Yes –** please elaborate and indicate how you would prefer to be contacted. i.e. Phone, Text, Letter, e-mail

Can we add this information to your Summary Care Record? Yes/No

Signed: Date:

|  |  |
| --- | --- |
| How often do you regularly exercise? | times per |
| Do you smoke? | If yes how much? |
| How much alcohol do you drink in a week? |  |
| Are you on a special diet? |  |
| How much exercise do you take a week? |  |
| Have any of your family developed heart disease before the age of 60? | Who? |
| Have any of your family developed heart disease later than 60? | Who? |
| Have any of your family had strokes? | Who? |
| Have any of your family been diabetic? | Who? |
| Have any of your family got Asthma? | Who? |
| Have any of your family had cancer?  (especially Breast, Ovarian and Bowel cancer) | Who? |

**REGULAR MEDICATION** – Please list strength and dosage

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**FEMALE PATIENTS** over 16 years

|  |  |
| --- | --- |
| How many pregnancies have you had? |  |
| How many children have you had? |  |
| When do you think your last smear was? |  |
| Do you use any form of contraception? | Which one?  If coil, when was it fitted? |

**ALCOHOL USE** (Please tick the appropriate boxes)

|  |  |
| --- | --- |
| How often do you have a drink containing alcohol? | N/A Never (0) Monthly or less (1)  Two to four times a month (2)  Two to three times a week (3)  Four or more times a week (4) |
| How many units of alcohol do you drink on a typical day when you are drinking? | N/A 1 - 2 (0) 3 - 4 (1) 5 - 6 (2)    7 - 9 (3) 10 + (4) |
| How often have you had 6 or more units if female, or 8 units or more if male, on a single occasion in the last year? | N/A Never Less than monthly (1)  Monthly (2) Weekly (3) Daily (4) |

**SUMMARY CARE RECORD** – Care professionals in England use an electronic record called the Summary Care Record (SCR). This can provide those authorised care professionals, involved in your direct care, with faster secure access to key information from your GP record. Your SCR will not be used for any other purpose.

Your SCR includes the following basic information; **Medication** you are taking, **Allergies** you suffer from and any **bad reactions** to medicines.

You can choose to include more information in your SCR. If you would like to do this, please complete the information on the Summary Care Record Patient Consent Form.

If you choose to opt out of the scheme, then you will need to indicate your preference on the Summary Care record Patient Consent Form.

**Summary Care Record Patient Consent Form**

Having read the information overleaf, 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: ……….................................

Surgery Name:…………………………………… Surgery Location: …………………………

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.

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

**Information for new patients: about your Summary Care Record**

**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.

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

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

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

|  |  |
| --- | --- |
| Booking appointments | 🞏 |
| Requesting repeat prescriptions | 🞏 |
| Access to 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 “Keeping your online health and social care records safe and secure” – available online at: [www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Documents/PatientGuidanceBooklet.pdf](http://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Documents/PatientGuidanceBooklet.pdf) | 🞏 |
| 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 | 🞏 |
| I will contact the practice as soon as possible 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 | 🞏 |

|  |  |
| --- | --- |
| 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 passphrase sent | | | | |
| Level of record access enabled  Contractual minimum √  Other……………………. ……… | | | Notes / explanation | |