Please complete in BLOCK CAPITALS and tick the boxes as appropriate.

**PATIENT DETAILS:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Title | Mr |  | Mrs |  | Miss |  | Ms |  | Date of birth |  D |  D | M | M | Y | Y | Y | Y |
| Surname |  | First names |  |
| Previous Surname |  | Sex | M / F | Nationality |  |
| University & Course Duration |  | Job Title(Non-Student) |  |
| Home Address: |
|  Postcode: |
| Tel No: |  | Mobile No: |  | Work:  |  |
| E-mail Address: |

**PROOF OF IDENTITY:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Birth certificate |  | Driving licence |  | Passport |  | Utility bill |  | Other: |  |

**NEXT OF KIN:**

|  |
| --- |
| Name: Relationship:  |
| Address:  |
| Contact Number: |
| Are you happy for the surgery to contact this person in an emergency?  |  **YES** |  **NO** |
| If Next of Kin for a relative who is in a care home, is a Deprivation of Liberty Safeguards (DoLs)Sin place?  |  **YES** |  **NO** |

**CARER**

|  |  |  |
| --- | --- | --- |
| **DO YOU HAVE A CARER?** |  **YES** |  **NO** |
| Is the Carer registered at this surgery? |  **YES** |  **NO** |
| *If YES, please give details:**Name: ………………………………………………………………………………………………………………………………………**Address: ………………………………………………………………………………………………………………………………………* |
| *Please confirm that you agree to your carer being given permission to discuss your medical matters with the Practice.* ***I DO/DO NOT*** *(delete the statement that does not apply) give permission for my carer named above to have* *permission to deal with medical matters on my behalf.* |
|  |
| **ARE YOU A CARER FOR ANYONE?** |  **YES** |  **NO** |
| Is the person registered at this practice? |  **YES** |  **NO** |
| *If YES, please give details:**Name: ………………………………………………………………………………………………………………………………………**Address: ………………………………………………………………………………………………………………………………………* |

**Disabilities:**

|  |
| --- |
| Are you registered disabled? Y / N ( If yes, please give details: |
| Do you have any communication or information needs which are related to a disability, impairment, sensory loss or learning disability? |  **YES** | **NO** |
| When we write to you or contact you, do you need us to communicate in a particular way? |  **YES** | **NO** |

If you have answered **NO** to both questions please continue. If you have answered **YES** please complete the Accessible Information Needs Questionnaire.

**CHILDREN:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Child(ren) | Date of Birth | Current Nursery/School | Disability? |
|  |  |  |  |
|  |  |  |  |
|  |
|  |
| Are you a carer for any other children? | **YES** | **NO** | Do you have parental responsibility? |  **YES** |  **NO** |
| Any history of Female Genital Mutilation(FGM)/Cutting? | **YES** | **NO** | Any previous involvement withChildren’s Social Care? |  **YES** |  **NO** |

**ETHNICITY:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| White |  | British |  | Black or Black British |  | Caribbean |
|  | Irish |  |  | African |
|  | Other (Please Specify) |  |  | Other (please specify) |
|  Asian or Asian British  |  | Indian |  | Mixed |  | White & Black Caribbean |
|  | Pakistani |  |  | White & black African |
|  | Bangladeshi |  |  | White & Asian |
|  | Chinese |  |  | Other (please specify) |
|  | Other (Please Specify) |  |
|  |
| Eastern European  |  | Polish |  | What is your first language? |  |
|  | Romanian  |  |
|  | Czech Republic |  |
|  | Other (please specify) |  | Do you require an interpreter? | Yes / No |

|  |  |
| --- | --- |
| What is your faith or religion, if any? |  |

**Medication:**

|  |  |  |
| --- | --- | --- |
| Medication | Reason for taking | Dose |
|  |  |  |
|  |  |  |
| Are you allergic to any medications? | **YES** | **NO** | If so, please give details |
| Do you have any other allergies? | **YES** | **NO** | If so, please give details |

**Medical information:**

Do **YOU** have or have you experienced?

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **YES** | **NO** |  | **YES** | **NO** |  | **YES** | **NO** |
| Epilepsy |  |  | Blindness / Glaucoma |  |  | High blood pressure |  |  |
| Diabetes |  |  | Heart Attack / Stroke |  |  | Asthma |  |  |
| Cancer |  |  | Depression /mental illness |  |  | Thyroid |  |  |
| Chronic Kidney Disease |  |  | Blood Disorders |  |  |  |  |  |

Do any of your immediate family suffer from?

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **YES** | **NO** |  | **YES** | **NO** |  | **YES** | **NO** |
| Epilepsy |  |  | Blindness / Glaucoma |  |  | High blood pressure |  |  |
| Diabetes |  |  | Heart Disease |  |  | Asthma |  |  |
| Cancer |  |  | Depression/Mental Illness |  |  | Thyroid |  |  |
| Chronic Kidney Disease |  |  | Blood Disorders |  |  |  |  |  |
| Have you had a pneumococcal vaccination? | **YES** |  **NO** | Date: |

**Latent Tuberculosis Infection Screening**:

|  |  |  |
| --- | --- | --- |
| Are you between 16-35 years of age? |  **YES** |  **NO** |
| Have you arrived in the country in the last 5 years and never been screened for or treated for TB? |  **YES** |  **NO** |
| Born in the country with a high risk of TB or spent more than 6 months in a country with a high risk of TB in the past 5 years. |  **YES** |  **NO** |

If you answer **YES to ALL three** **questions** then please can you make an appointment for a free latent TB blood test.

**Smoking**:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Do you smoke? |  **YES** | **NO** | If no, Have you ever smoked? | **YES** | **NO** |
| Type of Tobacco: | CIGARETTES / CIGARS / PIPES / HAND-ROLLED / CHEWING | Amount per day: |  |
| Would you like advice on giving up smoking? | **YES** | **NO** | If Ex-Smoker, Date Stopped |  / / |
| **Alcohol**: *For the following questions please write the underlined letter which best applies in the appropriate box***N**ever / **L**ess than Monthly / **M**onthly / **W**eekly / **D**aily or Almost Daily |  |
| 1. *Men* How often do you have **8** or more drinks on 1 occasion? [ ]

*Women* How often do you have **6** or more drinks on 1 occasion? [ ]1. How often during the last year have you been unable to remember

 what happened the night before because you had been drinking [ ]1. How often during the last year have you failed to do what was

normally expected of you because of your drinking [ ]*For the following question please write the underlined letter which best applies in the appropriate box***N**o / Yes, But Not in The **L**ast Year / **Y**es, in The Last Year1. Has a relative, friend, doctor or other health worker been

 concerned about your drinking or suggested you cut down? [ ] |
| Wo 1 unit = ½ pint beer 1 small glass of wine 1 single spirit 1 small glass of sherry or 1 single aperitif |

**Exercise**:

|  |  |  |  |
| --- | --- | --- | --- |
| Amount of Exercise: | NEVER / LIGHT / MODERATE / HEAVY | Hours per Week: |  |
| Type of Exercise:  |  |

**Cervical Cytology**:

|  |
| --- |
| If you are Female and 25 or over:Have you had a cervical smear in this country?YES: Date \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ Place \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NO: Do you wish to have one? YES [ ]  Advised Book Appointment [ ]  NO [ ]  I do not wish to have a cervical smear: Dissent form Signed [ ]   |

|  |  |  |
| --- | --- | --- |
| Height \_\_\_\_\_\_\_\_\_\_\_\_\_\_cms | Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_kg | B/P \_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |

**Safeguarding**:

|  |  |  |
| --- | --- | --- |
| Have you ever experienced domestic abuse? | Yes / No |  |
| Are you currently experiencing domestic abuse? | Yes / No |  |
| Do you require support? |  |  |

|  |  |
| --- | --- |
| Would you be interested in joining our Patient participation Group?  |  Yes / No |

|  |  |  |
| --- | --- | --- |
| NAME (Print) | DATE | SIGNATURE |

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

**You can book appointments, order repeat prescriptions and even access your GP records online. It’s quick, easy and your information is secure.** For more information about keeping your healthcare records safe and secure please visit our website [www.halcyonmedical.co.uk](http://www.halcyonmedical.co.uk).

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

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)

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the practice |  |
| 2. I will be responsible for the security of the information that I see or download |  |
| 3. If I choose to share my information with anyone else, this is at my own risk |  |
| 4. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible |  |
| 5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible |  |
| 6. 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.  |  |
|  |  |
| **HOW WOULD YOU LIKE TO RECEIVE YOUR ACCESS LOG IN DETAILS? EMAIL/COLLECT FROM SURGERY** |
|  |  |
|  |  |
| Signature | Date |

# For practice use only

|  |  |
| --- | --- |
| Patient NHS number | Practice computer ID number |
| Identity verified by (initials) | Date | MethodVouching Vouching with information in record Photo ID and proof of residence  |
| Authorised by | Date |
| Date account created |
| Date passphrase sent |
| Level of record access enabledAll  Prospective  Retrospective Detailed coded record  Limited parts   | Notes / explanation |