STAFF USE ONLY

Please initial here. ☐

Trent View Medical Practice

CONFIDENTIAL REGISTRATION QUESTIONNAIRE

To help your doctor provide good medical care, please fill in the following details and hand in with your registration documents. If you are unsure of any of the questions please state.

PLEASE REMEMBER TO SIGN THE LAST PAGE

SURNAME	TITLE
FIRST NAME(S)	
DATE OF BIRTH	AGE
ADDRESS	
POSTCODE	EMAIL ADDRESS

ETHNIC ORIGIN (PLEASE TICK BOX)

White
- a)British ☐
- b)Irish ☐
- c)Other (Please specify) ☐

Mixed
- d)White & Black Caribbean ☐
- e)White & Black African ☐
- f) White & Asian ☐
- g)Other (Please specify) ☐

Asian/Asian background
- h)Indian ☐
- i)Pakistani ☐
- j)Bangladeshi ☐
- k)Other (Please specify) ☐

Black or Black British
- l)Caribbean ☐
- m)African ☐
- n)Other (Please specify) ☐

Chinese or other ethnic group
- o) Chinese ☐
- p)Other (Please specify) ☐

1. In which country were you born?
2. If you have come from abroad what date did you arrive in this country?

   Do you have a visa or work permit? **YES/NO** If **YES** please hand to reception for photocopying
3. What is your first language?

HOME CONTACT NUMBER	MOBILE

Do you have any communication needs? Please indicate.

Which area have you moved from?

Please give the full names of anyone else who lives at this address:

Name and address of next of kin/carer:

POSTCODE

Telephone number of next of kin/carer:

CARERS: If you are a carer for one of our registered patients please state patient name as we need to record the details on our database

NAME TELEPHONE NUMBER

ADDRESS

(Please ensure they have given you their permission to use this information

FAMILY HISTORY:

DISEASE	RELATION	AGE OF ONSET
Stroke		
Hypertension(High blood pressure		
Diabetes Mellitus		
Cancer (Please specify type)		
Heart Disease – Angina, MI, heart attack, vascular disease		
Any other (Please tick box) Asthma ☐ Epilepsy ☐ Glaucoma ☐		

YOUR MEDICAL HISTORY

Have you had any operations or significant medical conditions? **YES** **NO**

Please state with dates:

ARE YOU TAKING ANY PRESCRIBED MEDICINES/TABLETS AT PRESENT? **YES** **NO**

If YES please list with dose and how often taken.

<u>IF YES - PLEASE INCLUDE A RECENT REPEAT SLIP WITH THIS FORM</u>

ARE YOU ALLERGIC TO ANY MEDICINES? **YES** **NO**

If yes, please state

DO YOU HAVE ANY OTHER ALLERGIES? **YES** **NO**

If yes, please state

ARE YOU TAKING ANY MEDICINES/TABLETS OR HERBAL PREPARATIONS THAT YOU HAVE BOUGHT? **YES** **NO**

If yes, please state

WHEN WAS YOUR LAST TETANUS VACCINATION?

YOUR LIFESTYLE:

Your height:	Your weight:
Do you smoke? If so, how much?	
If you have 'given up' when did you stop?	
On average, how many units of alcohol do you drink per week?	
Do you follow any diet (religious or medical)?	
Do you take any regular exercise?	
What is your occupation?	

HAVE YOU ANY DISABILITY? **YES** **NO**

If so please state

HEALTH PROMOTION:

Do you wish to receive information on any of the following?

ALCOHOL	☐	**DIET**	☐	**OBESITY**	☐
EXERCISE	☐	**OSTEOPEROSIS**	☐	**SMOKING**	☐

DO YOU HAVE ANY SERIOUS WORK PROBLEMS WHICH AFFECT YOUR HEALTH?

CURRENT HOSPITAL SPECIALIST TREATMENT:

So far as you are aware, are you currently on any waiting list within the NHS for **ANY** operation or outpatients appointments? **YES** **NO**

Please give as many details as possible regarding the hospital, department, consultant, and any operation or procedure awaiting (including hospital number if known)

HOSPITAL	HOSPITAL NO	DEPARTMENT	PROCEDURE

FOR WOMEN ONLY:

WHEN WAS YOUR LAST CERVICAL SMEAR?

DATE	NORMAL/ABNORMAL

If it is more than 5 years since your last smear we can arrange one for you with the practice nurse.

HAVE YOU HAD A HYSTERECTOMY? **YES** **NO**

DATE IF YES

HAVE YOU EVER HAD A BREAST EXAMINATION? **YES** **NO**

DATE IF YES	NORMAL/ABNORMAL

HAVE YOU EVER HAD A MAMMOGRAM? **YES** **NO**

DATE IF YES	NORMAL/ABNORMAL

How many times have you been pregnant? ______________

How many children have you had? ______________

Are you taking/using a form of contraception? **YES** **NO**

If YES, what sort of contraception are you using? ______________

FOR CHILDREN ONLY:

WE STRONGLY RECOMMEND ALL CHILDHOOD VACCINES AVAILABLE

HAS YOUR CHILD BEEN IMMUNISED AGAINST THE FOLLOWING?

	YES	NO	DATES		
Diphtheria					
Whooping Cough (Pertussis)					
Tetanus					
HIB Meningitis					
Polio (drops)					
MMR (measles, mumps, rubella)					
Any other?					

FOR ADULTS ONLY:

If you have had any travel vaccinations in the last ten years, please list below

FOR ALL PATIENTS:

DO YOU CONSENT TO SHARING YOUR MEDICAL RECORDS WITH OTHER HEALTH PROFESSIONALS? **YES** **NO**

ANYTHING ELSE?

Is there anything else you want your new doctors to know?

Thank you very much for your help. We cannot complete your registration until you have attended the surgery for a registration interview. Please make an appointment with the Healthcare Assistant as soon as possible and if you are on any medication you will need to see the GP. Please ask a receptionist to make an appointment for you.

PLEASE SIGN BELOW

The information I have provided is correct and I apply to be included on the list of the Practice. I acknowledge receipt of an offer for a medical examination.

SIGNED ______________________

DATE ______________________

NHS
Digital

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 who 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.

- **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies for adverse reactions only.
- **Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies for adverse reactions and further medical information that includes: your 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.
- **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.

If you chose not to complete this consent form, a core Summary Care Record (SCR) **will** be created for you, which will contain only medications, allergies and adverse reactions.

Once you have completed the consent form, please return it to your GP practice.

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

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NHS Digital

Summary Care Record patient consent form

Having read the above information 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: ....

Date of birth: .... Patient's postcode: ....

Surgery name: .... Surgery location (Town): ....

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

For more information, please visit https://www.digital.nhs.uk/summary-care-records/patients, call NHS Digital on 0300 303 5678 or speak to your GP Practice.

For GP practice use only

To update the patient's consent status, use the SCR consent preference dialogue box and select the relevant option or add the appropriate read code from the options below.

Summary Care Record consent preference	Read 2	CTV3
The patient wants a core Summary Care Record (express consent for medication, allergies and adverse reactions only)	9Ndm.	XaXbY
The patient wants a Summary Care Record with core and additional information (express consent for medication, allergies, adverse reactions and additional information)	9Ndn.	XaXbZ
The patient does not want to have a Summary Care Record (express dissent for Summary Care Record – opt out)	9Ndo.	XaXj6

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