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| nEW PATIENT HEALTH QUESTIONNAIRE |
| ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL. |
| Name (Last, First, M.I.): |  |  | DOB: |  |
| Marital status:  | 🞎 Single 🞎 Partnered 🞎 Married 🞎 Separated 🞎 Divorced 🞎 Widowed |
| Gender: |  | **Gender at Birth:** |
| Pronouns:  | 🞎 He/Him 🞎 She/Her 🞎 They/Them |
| Sexual Orientation: | 🞎 Gay or Lesbian 🞎 Bisexual 🞎 Heterosexual (straight) 🞎 I don’t know/ I’m not sure 🞎 In another way (please state) |
| Home Telephone No: | **Mobile No:** | **Occupation:** |
| Home Address: |
| Name and Address of Previous GP: |
| Height: | Weight: | First Language?: |
|  |
| What is your ethnic group? Choose ONE option below to indicate your ethnic group  |
| 🞎 White British | 🞎 White and Black Caribbean | 🞎 Asian or Asian British | 🞎 Caribbean | 🞎 Any Other White (write in) |
| 🞎 Irish | 🞎 White and Black African | 🞎 Indian | 🞎 African | 🞎 Any Other Black (write in) |
| 🞎 White and Asian | 🞎 Black or Black British | 🞎 Pakistani |  |  🞎 Any Other Mixed (write in) |
|   |  | 🞎 Bangladeshi |   |  🞎 Any Other Asian (write in) |
|  |
| **Are you a carer?**  | 🞎 Yes | 🞎 No |  |
| **Do you have a carer?**  | 🞎 Yes | 🞎 No |  |
| If yes to either please provide details |
| **Do you have a Cervix and are over the age of 25** Yes No **Have you had a Cervical Smear Test within the past 3/5 years** Yes  No  Date Was it Normal? Yes  No Where was it done? GP / Hospital / Family Planning Clinic / Abroad / Other Have you had a hysterectomy? Yes  No If **YES**, was it because of cancer? Yes  No Have you had a mammogram? Yes  No  If yes, when? |
| PERSONAL HEALTH HISTORY |
| **Have you any allergies to medicines or anything else?**  | 🞎 Yes |  🞎 No |
| **Please name the allergy and the reaction you had** ……………………………………………………………………………….. |
| Immunizations and dates: | 🞎 Tetanus | 🞎 Polio | 🞎 Other please list |  |
| 🞎 Influenza | 🞎 Typhoid |  |  |
| 🞎 Pneumonia | 🞎 Yellow Fever |  |  |
| 🞎 MMR Measles, Mumps, Rubella | 🞎 Hepatitis A |  |  |
| Do you have any of the following/have had the procedure: |
| 🞎 Other (please specify | 🞎 Diabetes | 🞎 Epilepsy | 🞎 Heart Problems |  |
| 🞎 Asthma | 🞎 Cancer | 🞎 Thyroid Problems |  |
| 🞎 High Blood Pressure | 🞎 Stroke | 🞎 Mental Health  Problems |  |
| 🞎 Eczema/Hay Fever | 🞎 Blindness/Glaucoma | 🞎 COPD |  |
|  | 🞎 Hysterectomy | 🞎 Prostectomy |  |  |
| **If yes, please state the year(s) when you were first diagnosed/had procedure** |
| ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONDFIDENTIAL. |
| List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers |
| Name of Drug | Strength | Frequency Taken |
|  |  |  |
|  |  |  |
|  |  |  |
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|  |  |  |
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|  |  |  |
| HEALTH HABITS AND PERSONAL SAFETY |
| Exercise | 🞎 Exercise Physically Impossible |
| 🞎 Avoids even trivial exercise |
| 🞎 Enjoys light exercise |
| 🞎 Enjoys moderate exercise |
|  | 🞎 Enjoys heavy exercise |
|  | 🞎 Competitive athlete |
|  |  |
| Smoking | Do you smoke? | 🞎 | Yes | 🞎 | No |
| **If you do smoke, how many cigarettes or ounces of tobacco do you smoke per week? Do you vape?**  |
|   | Are you an ex smoker? | 🞎 | Yes | 🞎 | No |
|  |  |  |  |  |  |
| Alcohol | Do you drink alcohol? | 🞎 | Yes | 🞎 | No |
| If you drink alcohol please complete the Audit C test below for our records  |
| **AUDIT C TEST** |
|  | **Scoring SystemScore: Pease circulate appropriate answers below** | **Your Score** |
| **Questions** | **0** | **1** | **2** | **3** | **4** |  |
| 1.How often do you have a drink that contains alcohol? | Never | Monthly or less | 2-4 times per month | 2-4 times per week | 4+ times per week |   |
| 2. How many standard alcoholic drinks do you have on a typical day when you are drinking | 1-2 | 3-4 | 5-6 | 7-8 | 10+ |  |
| 3. How often do you have 6 or more standard drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| Please note that a total of 5+ indicates hazardous or harmful drinking and we would advise that you make an appointment with a doctor or a nurse at the practice to discuss this |
| FAMILY HEALTH HISTORY |
| Please complete below to indicate if any of your family have had any of the following |
|   |  Father | Mother | Brother | Sister | Other relative(please detail who) |
| High Blood Pressure | 🞎 | 🞎 | 🞎 | 🞎 |  |
| Heart Problems | 🞎 | 🞎 | 🞎 | 🞎 |  |
| Diabetes | 🞎 | 🞎 | 🞎 | 🞎 |  |
| Cancer | 🞎 | 🞎 | 🞎 | 🞎 |  |
| Other e.g. Stroke (please name illness) |  |  |  |  |  |
| ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL. |
| **Name & Address of Next of Kin**  |
| **Telephone No. of Next of Kin**  | **Relationship to Next of Kin** |
| **PATIENTS AGED 65 AND OVER ONLY OR THOSE WITH A CHRONIC DISEASE (e.g. asthma or diabetes)** |
| Have you had a ‘flu’ vaccination? | 🞎 | Yes  | 🞎 | No |
| Have you had a pneumococcal vaccination? | 🞎 | Yes | 🞎 | No |
| Have you had 2 or more doses of COVID-19 Vaccination | 🞎 | Yes | 🞎 | No |
| **GDPR (General Data Protection Regulation) Consent** |  |  |  |  |
| I give consent to be contacted by the surgery by SMS text | 🞎 | Yes | 🞎  | No |
| Do you require communication by a different method | 🞎 | Yes | 🞎  | No |
| If yes please explain needs  |  |  |  |  |
| I give consent to be contacted by the surgery by emailEmail address: | 🞎 | Yes | 🞎 | No |

**Thank you for taking the time to complete this form. You are invited to attend a new patient health check with one of our practice nurses. Please contact the surgery to book your appointment – you are able to make appointments online, by telephone and in person. If you would like to register for the online booking service please obtain an online registration consent from our reception.**

**Welcome to Queenhill Medical Practice**

Signed …………………………………………… Date…………………………………

**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.

* **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.

 **Register your Type 1 Opt-out preference**

The data held in your GP medical records is shared with other healthcare professionals for the purposes of your individual care. It is also shared with other organisations to support health and care planning and research.

If you do not want your personally identifiable patient data to be shared outside of your GP practice for purposes except your own care, you can register an opt-out with your GP practice. This is known as a Type 1 Opt-out.

Type 1 Opt-outs may be discontinued in the future. If this happens then they may be turned into a National Data Opt-out. Your GP practice will tell you if this is going to happen and if you need to do anything. More information about the National Data Opt-out is here: <https://www.nhs.uk/your-nhs-data-matters/>

You can use this form to:

* register a Type 1 Opt-out, for yourself or for a dependent (if you are the parent or legal guardian of the patient) (to **Opt-out**)
* withdraw an existing Type 1 Opt-out, for yourself or a dependent (if you are the parent or legal guardian of the patient) if you have changed your preference (**Opt-in**)

### This decision will not affect individual care and you can change your choice at any time, using this form. This form, once completed, should be sent to your GP practice by email or post.

**Details of the patient**

|  |  |
| --- | --- |
| **Title** |  |
| **Forename(s)** |  |
| **Surname** |  |
| **Address** |  |
| **Phone number** |  |
| **Date of birth** |  |
| **NHS Number (if known)** |  |  |  |  |  |  |  |  |  |  |

**Details of parent or legal guardian**

If you are filling in this form on behalf of a dependent e.g. a child, the GP practice will first check that you have the authority to do so. Please complete the details below:

|  |  |
| --- | --- |
| **Name** |  |
| **Address** |  |
| **Relationship to patient** |  |

#### **Your Decision**

**Opt-out**

I do not allow my identifiable patient data to be shared outside of the GP practice for purposes except my own care.

OR

I do not allow the patient above’s identifiable patient data to be shared outside of the GP practice for purposes except their own care.

**Withdraw Opt-out (Opt-in)**

I do allow my identifiable patient data to be shared outside of the GP practice for purposes beyond my own care.

OR

I do allow the patient above’s identifiable patient data to be shared outside of the GP practice for purposes beyond their own care.

### Your declaration

I confirm that:

* the information I have given in this form is correct
* I am the parent or legal guardian of the dependent person I am making a choice for set out above (if appliable)

**Signature**

**Date signed**

**When complete, please post or send by email to your GP practice**

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**For GP Practice Use Only**

|  |  |
| --- | --- |
| Date received |  |
| Date applied |  |
| Tick to select the codes applied | **Opt – Out - Dissent code:**9Nu0 (827241000000103 |Dissent from secondary use of general practitioner patient identifiable data (finding)|)  |  |
|  | **Opt – In - Dissent withdrawal code:**9Nu1 (827261000000102 |Dissent withdrawn for secondary use of general practitioner patient identifiable data (finding)|)] |  |