Do you have any special communication needs? ☐ Yes ☐ No

If yes: ☐ Sign Language ☐ Large Print

☐ Other.....

New Patient Health Questionnaire

Thank you for choosing to register with The Swan Medical Group, we are delighted to welcome you as a new patient. We will receive your medical records from your previous surgery in due course but this can take a few weeks, so we ask in the meantime for you to complete this health questionnaire so we have some medical information to help care for you and have ways we can contact you. All new patients need to provide photo ID and proof of address (please note this is not required for children with parent/guardian living at the same address).

CONFIDENTIAL MEDICAL REGISTRATION FORM

Please complete all pages in FULL using BLOCK capitals in BLACK INK

Surname			
First Names (in full)			
Previous Surnames			
Title		Gender	
Date of Birth (dd/mm/yyyy)		NHS Number	
Town & Country of Birth			
Address	Post Code:		
Telephone number		Mobile Number	
Email address			

Have you previously been registered at Swan Surgery or Liphook village Surgery? Yes ☐ No ☐

Occupation (if retired state 'retired' plus previous occuption)

Please help us trace your previous medical records by providing the following information:

Your Previous address in UK

Post Code:

Name of previous Doctor while at that address

Address of previous Doctor

Post Code:

Where did you last receive Treatment? Date:

ie GP, Walk in Centre, MIU, Emergency Department etc

What was the outcome of this visit? ie prescription

If you are from abroad:

Your first UK address Where registered with a GP

Post Code:

If previously resident in UK date of leaving

Date you first came to UK

If you are returning from the Armed Forces:

Addresss before enlisting

Post Code:

Start date (dd/mm/yy)

Enlistment end (dd/mm/yy)

Are you a dependent of a family member currently serving in the armed forces? Yes ☐ No ☐

Please tell us about yourself:

Are you a carer? ☐ Yes ☐ No

Do you have a carer? ☐ Yes ☐ No

If yes, please tell us the name & address of your carer

Are you happy for us to contact your carer about you? ☐ Yes ☐ No

Are you or your children currently under the care of any external agencies/services eg Social Services

If so, please give details below:

For patients <u>aged 85 or over</u>: (these are to help us assess if you may need additional clinical input)

In general, do you have any health problems that require you to limit your activities? ☐ Yes ☐ No

In general, do you have any health problems that require you to stay at home? ☐ Yes ☐ No

Do you regularly use a stick, walker or wheelchair to get about? (Please tick appropriate)

Stick for walking ☐

Uses zimmer frame ☐

Dependence on wheelchair ☐

In case of need, can you count on someone close to you? ☐ Yes ☐ No

Do you need someone to help you on a regular basis? ☐ Yes ☐ No

Please provide details if the person is different from the information you have provided as your carer.

Personal Medical History

Have you ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below:

Condition	**Year diagnosed**	**Ongoing**
		Yes/No
		Yes/No
		Yes/No

Blood Pressure:	Has it been checked in the past 3 years?	Yes/No
	If yes, was it high?	Yes/No

Family History

Have any close relatives (*father, mother, sister, brother only*) ever suffered from any of the following: (please indicate who in the boxes)

Heart attack	Stroke	Diabetes	High blood pressure	Asthma	Glaucoma	Cancer

Immunisations

Immunisation	**Year**	**Immunisation**	**Year**
Tetanus		Polio	
Typhoid		Yellow Fever	
Hepatitis A		Hepatitis B	

Allergies

Please list any allergies you have to any drugs/medication:

Name of medication	**What was the problem or upset?**

List of current medication

If you have a copy of your repeat medications, please pass to Reception to copy

Name of medication	**Dosage**

Please state if you are taking cytotoxics or similar risk meds either from previous GP, hospital or private Doctor **(e.g. Methotrexate, Leflunomide, Azathioprine, Mercaptopurine, Hydroxychloroquine, Sulfasalazine, Mesalazine, Ciclosporin), or Lithium (Priadel/Camcolit)**

Lifestyle

Please enter your height & weight

Height in cm's:	Weight in kilos:

Lifestyle smoking

Do you smoke ☐ Yes ☐ No

If yes, do you smoke ☐ Cigarette ☐ Cigars ☐ Pipe ☐ Rolls own tobacco ☐ Electronic Cigarette

Are you an ex-smoker? ☐ Yes ☐ No When did you give up?

How many cigarettes/cigars do you smoke daily: ☐ <1/day ☐ 1-9/day ☐ 10-19/day ☐ 20-39/day ☐ 40+/day

If you smoke a pipe how many ounces a week?

Would you like help to quit smoking? ☐ Yes ☐ No

If you are a smoker and would like help and advice on how to give up, please contact Quit4Life:
0845 602 4663 or go to www.quit4life.nhs.uk

Lifestyle alcohol

Do you drink alcohol: ☐ Yes ☐ No If yes, please answer the following questions:

How many alcoholic units do you drink per week on average? ☐ 1-4 ☐ 5-10 ☐ 11-15 ☐ 16-20 ☐ 21+

Units guide:
Single spirit = 1 unit Small wine (125ml) = 1.5 units Pint beer = 2 units

Lifestyle exercise

Do you exercise ☐ Yes ☐ No If yes, please answer the following questions

What exercise do you do?

How often do you exercise?

Female patients only

Are you currently, or think you may be pregnant? ☐ Yes ☐ No

Do you have any children? ☐ Yes ☐ No If yes, how many?

Which method of contraception (if any) are you using at present?

If you have had a Coil fitted, what date:

Have you had a cervical smear test? ☐ Yes ☐ No If yes, date

(If yes, what was the result, if known)

Ethnicity

Please indicate your ethnic origin:

Language	What is your first language?		Is an interpreter required?	Yes/No

Next of kin

Title

First Name

Surname

Tel. contact number

Relationship to patient

For Patients aged 65 and over

Do you hold a living will? ☐ Yes ☐ No

(Documentation regarding your personal wishes in respect of medical intervention at the time of serious illness, i.e. resuscitation etc)

Pharmacy Nomination

We can now send your prescriptions to the pharmacy electronically for you, reducing the amount of paper used and making collecting your prescription easier for you. Please fill in the details below so that we can add them to the system. We will clear any previously nominated pharmacy as part of our registration process so you will need to complete the section below, even if you already have a nominated pharmacy

Name of Pharmacy

Address:

Online Access

Name:

DOB:

The Swan Medical Group offers our patients the ability to book, change and cancel telephone appointments and request repeat prescriptions via a secure online portal or smart phone app. You

will also have access to your Medical Record including immunisations, test results and consultations.

Your registration letter for Patient Access will be emailed to you once you are registered with the surgery.

I wish access to my medical record online and understand and agree with each statement:

1. I will be responsible for the security of information that I see or download	☐
2. If I choose to share my information with anyone else, this is at my own risk	☐
3. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without any agreement	☐
4. If I see information in my record that is not about me or inaccurate, I will contact the practice as soon as possible	☐
5. 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	☐

Please tick below to **OPT OUT** of this service

☐ I **DO NOT** wish to have access to online services

Data sharing consent choices

Hampshire Health Record (HHR)

The Hampshire Health Record is a local scheme which allows Out of Hours, Ambulance and Emergency services as well as GPs and Hospital Consultants access to medical record data. The data made available on the HHR is limited; it includes allergy information, medication, diagnoses, tests and treatments. It does not include any information relating to sexual health, abuse or complaints.
Patient consent will be required by ANYONE accessing their records (unless they are unconscious).
After reading the above CAREFULLY If you would like to Opt Out of the HHR, please tick below:

I would like to OPT OUT of the HHR	Signed:	Date:

Summary Care Record (SCR)
The Summary Care Record is a national programme and will enable healthcare professionals across the country to access the SCR database and patient information.

The SCR will consist of patient information which will be uploaded from our clinical system on a regular basis. This information will be very limited:

- Medication
- Allergies
- Adverse drug reactions

You will be automatically included in the SCR unless you tick otherwise

Patient consent will be required by ANYONE accessing their records (unless they are unconscious).

After reading the above CAREFULLY If you would like to Opt Out of the SCR, please tick below:

I would like to OPT OUT of the SCR	Signed:	Date:

Where you have provided information on how to contact you, can you confirm you are happy for Swan Medical Group to contact you by the following:

By email ☐ Yes ☐ No This will be to send you letters, the surgery newsletter and other relevant information

By text ☐ Yes ☐ No This will be to send you reminders of appointments via text and other relevant information

How did you hear about Swan Medical Group? Please tick one:

Our website ☐ Recommendation ☐ NHS Choices ☐

Other (please specify) ☐

Signature

I confirm that the information I have provided is true to the best of my knowledge.

Signed Date

Signature of patient ☐ Signature on behalf of patient ☐

STAFF USE ONLY – ID checked	**Initials:**	**Date:**

Proof of Identity (Please provide 1 form of photo ID and 1 proof of address).

Birth Certificate ☐ Driving Licence ☐ Passport ☐ Utility Bill ☐

Solicitor's Letter ☐ Offer of Tenancy ☐ Allowance Book ☐ Other

Access To Your Records By Named Representative

We run a strict confidentiality rule which is designed to protect your interest. We will not give out any medical information about you without your specific consent to anybody including partners, carers or relatives. On occasion we get asked to give results about investigations and test or hospital appointments to carers or partners. There maybe a good reason for this. Prior to asking us to allow another person to access information from your records we would like you to consider this very carefully. We have written some, but not all of the potential difficulties below.

We cannot differentiate what test result or hospital visit reports are allowed to be accessed. **Once set up, our computer will show that access is allowed to ALL your results to the named person.**

For example:
Allowing your partner to collect your stool result following a trip abroad maybe convenient *BUT* you may not want them to have access to future results, or the result of tests before you are aware of them.

Once set up the access will continue until you inform us otherwise. This may limit your ability to talk about issues at a time of your choosing or keep some results confidential. A partner collecting regular routine blood tests may become concerned when suddenly access is denied.

Relationships and circumstances change over time. Some results or investigations could be damaging if known by others. This could impact particularly at times of relationship difficulties. Similarly your partner may develop depression or be stressed and you may not wish to share a positive screening test which may turn out to be nothing. At the Swan Medical Group we believe the current system is the best whereby **only you** are able to access your results. Only in exceptional circumstances and after full consideration should you allow another person to access any information from your medical records on your behalf.

If you feel that your circumstances merit taking this step please complete below.

I (name)…… of (address)……..

……..have read the above and considered the potential problems.

I give consent for (name) …….. (Relationship)…….. to have access to all my investigation results and hospital reports held by Swan Medical Group. I accept any problem this may cause me. I take responsibility to cancel this access in writing if circumstances change and accept that Swan Medical Group will grant access to my named representative until that time.

Signed…….. Date ……