Liphook Village SURGERY

THE SWAN SURGERY
Caring for you, by knowing you.

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

If yes: ☐ Sign Language ☐ Large Print ☐ Other

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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

Surname

First Names (in full)

Previous Surnames

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Male ☐ Female

Date of Birth (day/month/year) NHS Number

Town & Country of Birth

Address

Post Code:

Telephone number Mobile Number

Email address

Occupation (if retired state 'retired' plus previous occupation

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:

Enlistment end (dd/mm/yy)

Service/ Personnel number

Do you have a family member that has served 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

For patients aged 85 or over: (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? ☐ Yes ☐ No

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
		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

Lifestyle

Please enter your height & weight

Height:	Weight:

Lifestyle smoking

Do you smoke ☐ Yes ☐ No

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

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)

Have you had a hysterectomy Yes/No If yes, date

Ethnicity

Please indicate your ethnic origin:

☐ British or mixed British ☐ Irish ☐ African ☐ Caribbean ☐ Indian ☐ Pakistani
☐ Bangladeshi ☐ Chinese ☐ Other (please state)
☐ Decline to state

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

Next of kin

Name

Tel. contact number

Relationship

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)

NHS Organ Donor Registration

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick boxes that apply.

☐ Any of my organs and tissue or

☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

Signature confirming my agreement to organ/tissue donation	Signed:	Date:

NHS Blood Donor Registration

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood. Tick here if you have given blood in the last 3 years ☐

Signature confirming consent to inclusion on the NHS Blood Donor Register	Signed:	Date:

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).

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

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

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 ☐

Please note that if you submit this form online, your registration will not be complete until you come into the practice to sign the form and show your ID.

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