**Welcome to The Old Dairy Health Centre**

As it can take several weeks before we receive your medical records please respond to the following questionnaire.

PLEASE WRITE YOUR DETAILS IN CLEAR BLOCK CAPITALS

# Full Name: Date of Birth:

/ / **Address: Post Code:** \_ **Occupation: Landline Number: Mobile Number**:

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |  |

**Partnership status:**

Single ☐ Separated☐ Divorced☐ Married☐ Co-habiting☐ Widowed☐

**Next of Kin Details**

**Name: Relationship to You: Tel No of Next of Kin: Address of Next of Kin:**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |  |

**Email Address:**

***FOR OFFICE USE***

|  |  |  |
| --- | --- | --- |
| Checked by: |  | |
| Date: Proof Seen  Photo ID: Address: | | |
| Catchment Area | |  |
| Telephone No. | |  |
| Email Details | |  |
| Previous GP | |  |
| Previous Address | |  |
| Ethnicity | |  |
| Main Language | |  |
| Family History | |  |
| Smoking Status | |  |
| Alcohol | |  |
| Height/Weight | |  |
| Patient Consent | |  |
| Inform Named GP | |  |
| EPS | |  |
| Carer Forms given | |  |
| PPG Form given | |  |
| HIV Test | |  |
| All form complete | |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **ETHNICITY -** please indicate the ethnic group to which you feel you belong: | | | | | |
| **White** | | **Black** | | **Asian** | |
| ☐ | British | ☐ | African | ☐ | Bangladeshi |
| ☐ | Irish | ☐ | Caribbean | ☐ | Indian |
| ☐ | Other White Background | ☐ | Black British | ☐ | Pakistani |
| **Mixed Background** | | ☐ | Other Black Background | ☐ | Asian British |
| ☐ | White/Black Caribbean | **Other Backgrounds** | | ☐ | Chinese |
| ☐ | White/Black African | ☐ | Chinese British | ☐ | Other Asian Background |
| ☐ | White/Asian | ☐ | Vietnamese British | ☐ | Vietnamese |

|  |  |  |
| --- | --- | --- |
| **RELIGION** |  | |
| What religion are you? | | Religion None ☐ |

|  |  |
| --- | --- |
| **LANGUAGE AND COMMUNICATION** | |
| What is your main spoken language? What language do you prefer to read? | |
| Do you have difficulty hearing, or need hearing aids; or need to lip-read what people say? | Yes ☐ No ☐ |
| Do you have difficulty with memory or ability to concentrate, learn or understand? | Yes ☐ No ☐ |
| Can you read English? | Yes ☐ No ☐ |
| Do you have difficulty speaking or using language to communicate or make your needs know? | Yes ☐ No ☐ |
| What is the best way to send you information? Telephone☐ Text relay☐ SMS☐ Letter☐ Email☐ Other: | |
| Do you need a format other than standard print? Yes☐ No☐ (If yes, which of the following?) Braille☐ Electronic audio format☐ Easy Read☐ Large Print☐ Other: | |
| Do you need the assistance of a Communication Professional? Yes☐ No☐ (If yes, which of the following?)  Interpreter☐ Interpreter for Deaf-Blind people☐BSL Interpreter☐ Makaton Interpreter☐ Notetaker☐ Tadoma Interpreter☐ Lipspeaker☐ Sign Language Translator☐ Speech to Text Reporter☐ | |
| Do you need an advocate? (Someone to support you communicate or express your point of view) Yes ☐ No ☐ (If yes, please state their name and relationship to you): | |

|  |  |  |
| --- | --- | --- |
| **MEDICAL HISTORY -** Please give details of the following if applicable: | | |
|  | **Year(s)** | **Details** |
| **Operations** |  |  |
| **Injuries/Fractures** |  |  |
| **Illnesses** |  |  |
| **Anaesthetics** |  |  |

**ALLERGIES:** are you allergic to any medication, food, animals, etc.? **Yes**☐ *(please state which)* **No**☐

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **ONGOING MEDICAL PROBLEMS** | | | | | | | | | | | | |
| Stroke☐ | Asthma ☐ | | Cancer ☐ | Diabetes ☐ | Epilepsy ☐ | | | Angina ☐ | | Mental Health Issues ☐ | | |
| Glaucoma ☐ | | Heart Disease ☐ | | High Blood Pressure☐ | | | High Cholesterol ☐ | | | | Thyroid Disease ☐ | |
| Kidney Disease ☐ | | | Learning disabilities ☐ | | | Depression ☐ | | | Lung Disease ☐ | | | Dementia ☐ |
| Other (Please give details): | | | | | | | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **MEDICATION:** Are you on regular medication? If so, please list the names of the medication, dosage and how often you take them, or **attach a list of your medication from your previous surgery**. | | | |
| **Medication Name** | **Dosage/How Often** | | |
|  |  | | |
|  |  | | |
| The **ELECTRONIC PRESCRIPTION SERVICE (EPS)** is a NHS Service. It gives you the chance to change how your GP sends your prescription to the place you choose to get your medicines or appliances from. Your prescription will be sent electronically to the pharmacy of your choice. **This means you will not need to come into the surgery to collect your prescription** as it will be prepared and ready for collection at your chosen pharmacy.  **PLEASE NOTE THAT THIS DOES NOT APPLY TO PATIENTS WITH A DOSSETT BOX OR PATIENTS WHO ARE ON A CONTROLLED MEDICATION.**  **For more information about EPS visit** [**www.cfh.nhs.uk/eps**](http://www.cfh.nhs.uk/eps) **or ask one of our receptionists.** | | | |
| Would you like to **subscribe to EPS** or have you previously nominated a pharmacy to send your prescription electronically to? | | Yes ☐ | No ☐ |
| If yes please provide the name of your nominated pharmacy and their **POST CODE**: | | | |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Do you have a family history of:** (please tick) | **Mother** | **Father** | **Sister** | **Brother** | **Aunt** | **Uncle** | **Maternal** | | **Paternal** | |
| **Grand Mother** | **Grand Father** | **Grand Mother** | **Grand Father** |
| **Heart disease** |  |  |  |  |  |  |  |  |  |  |
| **Angina** |  |  |  |  |  |  |  |  |  |  |
| **Hypertension** |  |  |  |  |  |  |  |  |  |  |
| **Diabetes** |  |  |  |  |  |  |  |  |  |  |
| **Asthma** |  |  |  |  |  |  |  |  |  |  |
| **Epilepsy** |  |  |  |  |  |  |  |  |  |  |
| **Dementia** |  |  |  |  |  |  |  |  |  |  |
| **Depression** |  |  |  |  |  |  |  |  |  |  |
| **Glaucoma** |  |  |  |  |  |  |  |  |  |  |
| **High cholesterol** |  |  |  |  |  |  |  |  |  |  |
| **Stroke/TIA** |  |  |  |  |  |  |  |  |  |  |
| **Thyroid Disease** |  |  |  |  |  |  |  |  |  |  |
| **Mental Health Issues** |  |  |  |  |  |  |  |  |  |  |
| **Kidney Disease** |  |  |  |  |  |  |  |  |  |  |
| **Lung disease** |  |  |  |  |  |  |  |  |  |  |
| **Learning Disabilities** |  |  |  |  |  |  |  |  |  |  |
| **Cancer (*please state which type)*** |  |  |  |  |  |  |  |  |  |  |
|  | | | | | | | | | |

|  |  |
| --- | --- |
| **DIET:** How healthy is your diet? Poor ☐ Average ☐ Good ☐ | |
| How many portions of fruit/vegetables/salad do you eat per day? | |
| Do you eat fried food regularly? | Yes ☐  No ☐ |
| Do you drink plenty of water? | Yes ☐ If yes how may glasses/Litres per day? No ☐ |
| Do you drink coffee? | Yes ☐ If yes how many cups per day? No ☐ |
| Do you have a special diet, i.e. low salt, vegetarian, vegan, gluten free? | |



|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SMOKING STATUS** | | | | |
| Do you smoke? | Yes ☐ | Never ☐ | Stopped ☐ (Please state when) | / / |
| If yes/stopped **how many** do/did you smoke per day? **Cigarettes Roll ups Cigars** | | | | |
| Would you like help to stop smoking? | | | **Yes** ☐ **No** ☐ |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **ALCOHOL** | | | | | | | |
| **UNIT GUIDE**  **1 unit is typically:**  Half-pint of regular beer, lager or cider; 1 small glass of low ABV wine (9%); 1 single measure of spirits (25ml)  **The following drinks have more than one unit:**  A pint of regular beer, lager or cider, a pint of strong/premium beer, lager or cider, 440ml regular can cider/lager, 440ml “super” lager, 175ml glass of wine (12%) | | | | | | | |
|  | | | | | | | |
| **Do you drink alcohol?** Yes ☐ No ☐ | If yes, how many units of alcohol do you drink per  week? | | | | | | |
| **About your alcohol intake – Please answer the questions below by ringing round the answers.** | | | | | | | |
| How often have you had 8 or more units on a  single occasion in the last year? | Never | Less than  monthly | | Monthly | Weekly | | Daily or  almost daily |
| How often during the last year have you been unable to remember what happened the night  before because you had been drinking? | Never | Less than monthly | | Monthly | Weekly | | Daily or almost daily |
| How often during the last year have you failed to  do what was normally expected of you because of your drinking? | Never | Less than monthly | | Monthly | Weekly | | Daily or almost daily |
| Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down? | No | | Yes, but not in the last year. | | | Yes, during the last year. | |

|  |  |
| --- | --- |
| **CONTRACEPTION** | |
| Are you using contraception? | Yes ☐ No ☐ Not applicable ☐ |
| If yes which contraception are you using? | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **FEMALE PATIENTS ONLY** | | | | | |
| Have you ever been pregnant? Yes ☐ No ☐ (If yes, how many of the following have you had?): | | | | | |
| Live Births Date(s): | Still Births Date(s): | | Terminations Date(s): | Miscarriages Date(s): | |
| **Have you had a Smear Test?** Yes ☐ No ☐ (If yes please give details of your most recent smear) | | | | | |
| Date of smear: | | Where did you have it? | | | Result: |
| Have all your smear tests been normal/negative? Yes ☐ No ☐ If ‘No’ please give details: | | | | | |
| **Have you had a mammogram?** Yes ☐ No ☐ If yes: When: Result: | | | | | |

|  |  |
| --- | --- |
| **EXERCISE:** Do you do regular exercise? | **Yes** ☐ **No** ☐ |
| **If yes, please state what kind and how often**: | |

|  |  |
| --- | --- |
| **WEIGHT:** Kg or st lbs | **HEIGHT:** cm or feet inches |

|  |  |
| --- | --- |
| **CHILDREN** | |
| Do you have any children? Yes ☐ No ☐ |  |
| If ‘Yes’, how many? How old are they? Do your children live with you? Yes ☐ No ☐  Are they registered with our Practice/going to be registered with our Practice? Yes ☐ No ☐  If ‘No’ please give name of Practice where registered ………………………………………………….. | |

|  |  |
| --- | --- |
| **HIV TEST** | |
| It is Practice policy to offer all new patients an HIV test. If you decided you would like a test, we will contact you shortly. If you are unsure and would like to speak to someone, we will arrange a telephone consultation with a clinician for you to discuss this further. | |
| Do you wish to have an HIV test? | Yes ☐ No ☐ Not sure ☐ |

|  |  |
| --- | --- |
| **CARERS** | |
| Are you a Carer? (Do you care for an elderly or disabled person?) | Yes ☐ No ☐ |
| Is the person you care for also a patient? | Yes ☐ No ☐ |
| If ‘Yes’ please give patient’s name and address below. You and the person you care for will also need to complete our Carer Forms – please ask at Reception.  …………………………………………………………………………………………………..  ………………………………………………………………………………………………….. |  |
| Are you Cared for? (Are you elderly or disabled and need a friend/relative to help you live your daily life?) | Yes ☐ No ☐ |
| If ‘Yes’ please give the carer’’s name and address below. You and the person who cares for you will also need to complete our Carer Forms – please ask at Reception.  …………………………………………………………………………………………………..  ………………………………………………………………………………………………….. |  |
| Are you a Foster Carer? | Yes ☐ No ☐ |

|  |  |  |  |
| --- | --- | --- | --- |
| **PATIENT CONSENT** | | | |
| Do you give consent for the Practice to leave you messages on your **ANSWERPHONE**? | I give consent ☐  I **do not** give consent ☐ | Mobile ☐ Landline ☐ Both ☐ | |
| Do you give consent for the Practice to contact you via **TEXT/SMS?** | I give consent ☐  I **do not** give consent ☐ | Mobile ☐ Landline ☐ Both ☐ | |
| Do you give consent for the Practice to contact you via **EMAIL?** | I give consent ☐  I **do not** give consent ☐ |  | |
| Do you give consent for the Practice to leave messages with a (family member/friend/carer)? | I give consent ☐  I **do not** give consent ☐ | Please state their name(s) and relationship to you: | |
| Do you give consent for the Practice to give your prescription to a (family/member/friend/carer)? | I give consent ☐  I **do not** give consent ☐ | Please state their name(s) and relationship to you: | |
| **SUMMARY CARE RECORD**  Your Summary Care Record (SCR) is an electronic summary of your key health information. It includes any medicines you are taking and any allergies you may have. **Your SCR will help healthcare staff to care for you in an emergency or when your GP Practice is closed.** | | | I consent to a Summary Care Record ☐ |
| I **do not** consent to a Summary Care Record ☐ |
| **LOCAL CARE RECORD**  The Local Care Record enables healthcare professionals to view your medications, previous treatments, test results and any other clinical information electronically between your GP Practice and Guy’s and St Thomas’, King’s College Hospital and South London and Maudsley.  Information is only shared when it is needed to make your care and treatment safer, easier and faster and only with those people directly involved in your care. | | | I consent to a Local Care Record ☐ |
| I **do not** consent to a Local Care Record ☐ |
| **PATIENT PARTICIPATION GROUP**  Our PPG consists of members who attend our meetings and those who just wish to be kept informed via email. If ‘Yes’ please ask Reception for a PPG Form. | | Would you like to become a PPG member? Yes ☐ No ☐ | |

|  |  |
| --- | --- |
| Did someone help you to complete this form? | Yes ☐ No ☐ |

**Patient’s Signature**:

(I declare that the information I’ve given above is accurate and truthful)

**Date:** / /

***For Office Use Only:***

|  |  |  |
| --- | --- | --- |
| *Registration Information Entered on Computer* | *Name:* | *Date:* |

**Online Services Records Access**



**Patient information leaflet ‘It’s your choice’**



|  |  |
| --- | --- |
| If you wish to, you can now use the internet to book appointments with a GP, request repeat prescriptions for any medications you take regularly and look at your medical record online. You can also still use the telephone or call in to the surgery for any of these services as well. It’s your choice.  Being able to see your record online might help you to manage your medical conditions. It also means that you can even access it from anywhere in the world should you require medical treatment on holiday. If you decide not to join or wish to withdraw, this is your choice and practice staff will continue to treat you in the same way as before. This decision will not affect the quality of your care.  Subject to approval of your Online Service Registration Form, you will be given login details, so you will need to think of a password which is unique to you. This will ensure that only you are able to access your record – unless you choose to share your details with a family member or carer.  **The practice has the right to remove online access to services for anyone that doesn’t use them responsibly.** | **Repeat prescriptions online**  **GP View your GP**  **appointment It’s records s online Your**  **Choice**  **It will be your responsibility to keep your login details and password safe and secure. If you know or suspect that your record has been accessed by someone that you have not agreed should see it, then you should change your password immediately.**  **If you can’t do this for some reason, we recommend that you contact the practice so that they can remove online access until you are able to reset your password.**  **If you print out any information from your record, it is also your responsibility to keep this secure. If you are at all worried about keeping printed copies safe, we recommend that you do not make copies at all.** |

If you would like to register for Online Access, please complete the attached form and return it to reception. You will be asked to show photo ID before being registered.

If you would like someone to help you set up Patient Access and show you how to use it, please book an appointment with one of our Senior Administrators Tania or Zoe.

Before you apply for online access to your record, there are some other things to consider.

Although the chances of any of these things happening are very small, you will be asked that you have read and understood the following before you are given login details.

|  |  |
| --- | --- |
| **Things to consider** | |
|  | **Forgotten history**  There may be something you have forgotten about in your record that you might find upsetting. |
| **Abnormal results or bad news**  If your GP has given you access to test results or letters, you may see something that you find upsetting to you. This may occur before you have spoken to your doctor or while the surgery is closed and you cannot contact them. |
| **Choosing to share your information with someone**  It’s up to you whether or not you share your information with others – perhaps family members or carers. It’s your choice, but also your responsibility to keep the information safe and secure. |
| **Coercion**  If you think you may be pressured into revealing details from your patient record to someone else against your will, it is best that you do not register for access at this time. |
| **Misunderstood information**  Your medical record is designed to be used by clinical professionals to ensure that you receive the best possible care. Some of the information within your medical record may be highly technical, written by specialists and not easily understood. If you require further clarification, please contact the surgery for a clearer explanation. |
| **Information about someone else**  If you spot something in the record that is not about you or notice any other errors, please log out of the system immediately and contact the practice as soon as possible. |

# More information

For more information about keeping your healthcare records safe and secure, you will find a helpful leaflet produced by the NHS in conjunction with the British Computer Society:

Keeping your online health and social care records safe and secure [http://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Documents/PatientGuidanceBooklet.](http://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Documents/PatientGuidanceBooklet.pdf) [pdf](http://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Documents/PatientGuidanceBooklet.pdf)

# The Old Dairy Health Centre

**Application for online access to my medical record via Patient Access**

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name | |
| Address  Postcode | |
| 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. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement |  |
| 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 |  |

|  |  |
| --- | --- |
| Signature | Date |

*For practice use only*

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