LOXWOOD MEDICAL PRACTICE
Your partner for a healthier future

The Surgery, Farm Close, Loxwood, BILLINGSHURST
West Sussex RH14 0SU
Telephone 01403 752246 / 753499
Emergency 01403 752246 Fax 01403 752916
www.loxwoodmedicalpractice.co.uk

NEW PATIENT REGISTRATION PACK

Thank you for expressing an interest in registering yourself as a patient of Loxwood Medical Practice. Our registration list is open and we are able to register those patients who live within our boundary area.

In order to register you successfully we will need you to complete all the attached paperwork and to see a least two forms of identification. One should be in the form of a photo ID and the other show proof of where you live. Examples are:

- **PHOTO ID:** driving licence or passport
- **PROOF OF RESIDENCY*:** any utility bill which clearly displays your name and address.

**Examples include - phone bill, bank statements, oil bill, council tax bill, electricity or water bill, house/car/contents insurance - any type of bill will do.*

Please allow 2 working days for the surgery to complete the necessary paperwork.

After Registration
Once you are registered you will need to phone the surgery to book your new patient medical appointment with one of our nurses. You will need to bring along a urine sample (sterile containers available at reception) and this completed New Patient Health questionnaire.

You can also choose to register for SystmOnline which allows you to book and cancel your appointments, order repeat medication, view your summary care record and request access to view your coded medical record all online at a time convenient to you. Please ask reception for SystmOnline forms or download the forms from our website www.loxwoodmedicalpractice.co.uk

Children 5 years and under
Any children aged 5 years and under will need to have an additional pink form completed, which registers them with the health visitor. Forms are available at reception.

NEW PATIENT HEALTH QUESTIONNAIRE

To be completed by parent/guardian of under 16s

We would be grateful if you could complete this health questionnaire to enable us to update your medical records. Please bring the completed questionnaire to your new patient medical appointment.

SURNAME: **FIRST NAME:**

Former Name: **Date of Birth:**

Sex: **Age:**

House Name: **Marital Status:**

Road: **Occupation:**

Locality: **Company:**

Town: **Office Phone:**

Postcode:

Home Phone:

Mobile:

(I give consent to receive messages by text) ☐

E-mail:

(I give consent to receive messages by email) ☐

Carer – Do you look after someone?

Does someone look after you?

HEALTH QUESTIONS

When you first register we do not have access to your full past medical record. It would therefore be very helpful if you would complete the following questions.

Past Medical History - please list any serious illnesses, operations, accidents, allergies or disabilities. For women please include pregnancies and any problems with pregnancy or delivery.

Year:	**Problem:**

Medication – Please give details of any treatment or drugs that you use.

Drug Name & Strength: **Frequency of use:** **Condition Treated by drug:**

Continue on a separate sheet if required

DRUG ALLERGIES AND ADVERSE REACTIONS – if any treatment has upset you please give details

Drug Name: **Problem Caused:**

Other Allergies:

SMOKING

Smoking (please circle one)

Never Smoked / Ex-Smoker up to _____per day / Current Smoker up to _____per day

ALCOHOL USAGE QUESTIONNAIRE

UNITS	 **2**	 **1.5**	 **2**	 **1**	 **9**
	Pint of regular Beer/Lager/ Cider	Alcopop or Can of Lager	Glass of Wine (175ml)	Single Measure of Spirits	Bottle of Wine

How many units of alcohol do you consume in a week? _____

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink that contains alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many alcoholic drinks do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-8	10+	
How often do you have 6 or more alcoholic drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					Total	

OTHER FACTORS & FAMILY HISTORY

Other factors:

Please tick any of the following conditions that you suffer from:

- ☐ Asthma
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Angina
- ☐ Heart Attack
- ☐ Stroke

Family History:
Please list any illnesses that run in your family:

Mother's side:

Father's side:

Brothers & sisters:

Other:

Has any member of your immediate family (i.e. mother, father, brothers and sisters) had a heart attack or stroke under the age of 60?

What is your height?

What is your weight?

FEMALES ONLY

When was your last cervical smear?	**DATE**:
Was it normal?	☐Yes / ☐ No / ☐Don't Know
Have you been immunised against Rubella	☐Yes / ☐ No / ☐Don't Know
If not, do you know that you are immune from Rubella?	☐Yes / ☐ No / ☐Don't Know
Are you using a form of contraception?	☐Yes / ☐ No
Are you on hormone replacement therapy (HRT)?	☐Yes / ☐ No

ETHNIC GROUP

We are required by the Department of Health to request this information – however if you prefer to decline you can do so by ticking here ☐

White
☐ British
☐ Irish
Any other White background *(please write in)*.....

Mixed
☐ White and Black Caribbean
☐ White and Black African
☐ White and Asian
Any other Mixed background *(please write in)*.....

Asian or Asian British
☐ Indian
☐ Pakistani
☐ Bangladeshi
Any other Asian background *(please write in)*.....

Black or Black British
☐ Caribbean
☐ African
Any other Black background *(please write in)*.....

Chinese or other ethnic group
☐ Chinese
Any other *(please write in)*.....

What is your first language?	

COMMUNICATION NEEDS

Do you have any communication requirements? ☐

☐ Braille
☐ Large Print
☐ Translation service
☐ Sign Language

Any other *(please write in)*.....

Sharing and your consent

We would like to obtain your permission and consent to sharing your medical record with NHS England and the Health and Social Care Information Centre (HSCIC).
Please tick your preference to all three items;

1.Care.Data

I give consent to sharing my record with HSCIC ☐
I do not consent to sharing my record with HSCIC ☐

Full information about care.data is available on our website or you can call 03004563531

Sharing information can help improve understanding, locally and nationally, of the most important health needs and the quality of the treatment and care provided.

2. Summary Care Records (SCR)

A system intended to support clinical decisions in emergency care.

I would like to opt out of the Summary Care Records Programme and have completed the appropriate form ☐

For more information about summary care records visit www.hsic.gov.uk/scr/patients

Other NHS Organisations

Other NHS organisations which we may refer you to in the future can see your full electronic, medical record, if they use the same clinical software on their computers as we do, if you give your permission to sharing your full record. If you do not give permission to sharing, a printed summary of your past, relevant medical history is always sent with the original referral letter.

I give consent to sharing my record via TPP SystmOne ☐
I do not consent to sharing my record via TPP SystmOne ☐

A system intended to allow sharing (with consent) of the full electronic record allowing clinicians to make more informed decisions.

Please make sure you attend a 'New Patient Medical' appointment with a nurse.