# Patient Health Questionnaire for Adults

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## Patient Details

| Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ | Surname:<br><br>Previous Surname/s: | First Names: | Date of Birth: |
|---|---|---|---|
| Home Address:<br><br><br>Postcode: | | Home Tel:<br><br>Work Tel:<br><br>Mobile:<br><br>Email: | Main Spoken Language:<br><br>Occupation:<br><br>Marital Status: |
| Name & Address of Previous GP: | | | |

## Ethnic Group

| White | ☐ British |
|---|---|
| | ☐ Irish |
| | ☐ Other (please specify) |

| Black | ☐ Caribbean |
|---|---|
| | ☐ African |
| | ☐ Other (please specify) |

| Asian | ☐ Indian |
|---|---|
| | ☐ Pakistani |
| | ☐ Chinese |
| | ☐ Other (please specify) |

| Mixed | ☐ White + Black |
|---|---|
| | ☐ Pakistani |
| | ☐ Chinese |
| | ☐ Other (please specify) |

## Proof of Identity and Address Provider?

| ☐ Birth Certificate | ☐ Driving Licence | ☐ Passport | ☐ Utility Bill |
|---|---|---|---|
| ☐ Allowance Book | ☐ Solicitor's Letter | ☐ Offer of Tenancy | ☐ Other (please state) |

## Armed Forces Personnel

**We cannot register you unless your discharge date has passed!**

| Enlistment Date | |
|---|---|
| Discharge Date | |

**Medical Information**

| Please list any serious illnesses/operations/accidents/disabilities (and for women – any pregnancy related problems) and the year they took place. |
|---|
| |

Have you ever suffered from: (tick as appropriate) and add date of diagnosis if possible.

| | | | | | | |
|---|---|---|---|---|---|---|
| Epilepsy | ☐ Yes | ☐ No | | Blindness/Glaucoma | ☐ Yes | ☐ No |
| High Blood Pressure | ☐ Yes | ☐ No | | Diabetes | ☐ Yes | ☐ No |
| Heart Attack | ☐ Yes | ☐ No | | Depression | ☐ Yes | ☐ No |
| Stroke | ☐ Yes | ☐ No | | Asthma | ☐ Yes | ☐ No |
| Cancer | ☐ Yes | ☐ No | | COPD | ☐ Yes | ☐ No |
| Eczema/Hayfever | ☐ Yes | ☐ No | | | | |

| Are you registered disabled? (if yes please give details)<br>☐ Yes ☐ No | Details: |
|---|---|

| Please list any medicines being taken and the amount: |
|---|

| Are you allergic to any medicines and if so which?<br>☐ Yes ☐ No | Details: |
|---|---|

| Have you ever refused treatment/screening of any kind? if so, please give details.<br>☐ Yes ☐ No | Details: |
|---|---|

**Other Information**

| Do you have a carer? (if YES please give details)<br>☐ Yes ☐ No | Details |
|---|---|
| Are you a carer? If YES please give details of the person you care for) Please ask for a carers information pack.<br>☐ Yes ☐ No | Details: |
| Do you hold a Living Will? (A Living Will is documentation regarding your personal wishes in respect of medical intervention at the time of the serious illness)<br>☐ Yes ☐ No | Details: |

| Women:<br>Have you ever had a cervical smear? (If yes, when and where?)<br>☐ Yes ☐ No | Details: |
|---|---|

| Are you currently pregnant? ☐ Yes ☐ No<br>If yes how many weeks? ___________________<br>Are you taking any regular medication? ☐ Yes ☐ No<br>Do you require any appointment with the GP ☐ Yes ☐ No | Details of any medication: |
|---|---|

**Smoking**

Do You smoke? Yes ☐ No ☐

If 'no' have you ever smoked? Yes ☐ No ☐

If 'yes' how many cigarettes/cigars or ounces of tobacco per day? _______________

Would you like advice on giving up smoking? Yes ☐ No ☐

**Alcohol Consumption**

**1 drink = 1 pint of beer or 1 glass of wine or 1 single spirits**

| | **Never - 0** | **Less than monthly - 1** | **Monthly - 2** | **Weekly - 3** | **Daily or Almost Daily - 4** |
|---|---|---|---|---|---|
| **Men**<br>How often do you have EIGHT or more drinks on one occasion? | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Women**<br>How often do you have SIX or more drinks | ☐ | ☐ | ☐ | ☐ | ☐ |
| How often during the last year have you NOT been able to remember what happened the night before because you had been drinking? | ☐ | ☐ | ☐ | ☐ | ☐ |
| How often during the last year have you failed to do what was normally expected of you because of drinking? | ☐ | ☐ | ☐ | ☐ | ☐ |
| In the last year has a relative or friend or a doctor or a health worker been concerned about your drinking or suggested to cut down? | No<br>☐ | Yes, on one occasion<br>☐ | Yes, on more than one occasion<br>☐ | | |

**Height and Weight**

| **What is your Height?**<br><br>___________ | **What is your Weight?**<br><br>____________ |
|---|---|

**Family History**

| Please state in your family is there any serious illness, in particular heart disease, strokes, high blood pressure, diabetes or any inherited disease |
|---|
| |

| Please give name, relationship, address and telephone number of next of kin: |
|---|
| |

**For Patients aged 65 and over or those with a chronic disease (e.g. asthma or diabetes).**

| Have you ever had a flu vaccination? Enter date or 'Never' | |
|---|---|
| Have you had a pneumococcal vaccination: Enter date or 'Never' | |

**Feedback Information**

How did you hear about Orchard Medical Practice:

Orchard Website: ☐ Facebook: ☐ Word of Mouth: ☐

NHS Choices Website: ☐ Recommended by someone: ☐

Other (please state): ______________________________

I believe all the information in my new patient health questionnaire to be accurate and correct to the best of my knowledge (please sign and date below when you visit the practice)

Signature: _______________________________ Date: _______________________

Updated: January 2024

Orchard
Medical Practice

# Patient Care Text Messaging

Registration Form Declaration

I consent to the practice contacting me by text message for the purpose of appointment reminders and health promotion.

I acknowledge that appointment reminders by text are an additional service and that these may not take place on all/any occasion, and that the responsibility of attending appointments or cancelling them still rests with me. I can cancel the text message facility at any time.

Orchard Medical Practice **does not** offer a reply facility to enable patients to respond to texts directly.

Text messages are generated using a secure facility, however I understand that they are transmitted over a public network onto a personal telephone and as such may not be secure, however the Practice will not transmit any information which would enable an individual patient to be identified.

Patient's Name: ……………………………………….. Date of Birth: ………………

Address: ……………..………………………………………………………………..

…………………………………………………………………………………………..

Mobile Number: ………………………………………………..

*Please note: The Practice does not share mobile phone contact details with any external organisation.*

# 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.

a) Express consent for medication, allergies, and adverse reactions only. You wish to share information about medication, allergies, and adverse reactions only.

b) Express consent for medication, allergies, adverse reactions, and additional information. You wish to share information about medication, allergies and adverse reactions and further medical information that includes: Your significant 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.

c) 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.

Please note that it is not compulsory for you to complete this consent form. If you choose not to complete this form, a Summary Care Record containing information about your medication, allergies and adverse reactions and additional further medical information will be created for you as described in point b) above.

The sharing of this additional information during the pandemic period will assist healthcare professionals involved in your direct care and has been directed via the Control of Patient Information (COPI) Covid-19 – Notice under Regulation 3(4) of the Health Service Control of Patient Information Regulations 2002.

If you choose to complete the consent form overleaf, please return it to your GP practice.

You are free to change your decision at any time by informing your GP practice.

# Summary Care Record Patient Consent Form

Having read the above information regarding your choices, please choose one of the options below and return the completed form to your GP Practice:

Yes – I would like a Summary Care Record

□ Express consent for medication, allergies, and adverse reactions only.

or

□ Express consent for medication, allergies, adverse reactions, and additional information.

No – I would not like a Summary Care Record

□ Express dissent for Summary Care Record (opt out).

Name of Patient: ……………………………………………….............................................................

Address: …………………………………………………………………………………………………………………….

Postcode: ……………………………………… Date of Birth: ..................................................

NHS Number (if known): ……………………….........................................................................

Signature: ……………………………………………………….. Date: ……………………………………………

If you are filling out this form on behalf of another person, please ensure that you fill out their details above; you sign the form above and provide your details below:

Name: ………...................................................................................................................

Please circle one: Parent Legal Guardian Lasting power of attorney for health and welfare If you require any more information, please visit http://digital.nhs.uk/scr/patients or phone NHS Digital on 0300 303 5678 or speak to your GP practice.

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Consent Form

I, ____________________(**Forename Surname),** have today been given the opportunity to discuss sharing of my patient record and have read and understood the leaflet Sharing your GP record

I understand that the same record is used to store information recorded by different members of the care teams who are currently involved in providing my care, including but not limited to doctors' surgeries, district nurses, health visitors, physiotherapists, podiatrists, social care, and child health. I understand that I will be asked to give consent by each care team before they are able to access or add to any shared data about me.

**Share-out *Circle Your Choice**

I would* / would-not* like the information recorded at **Orchard Medical Practice** to be available to be seen by other care teams who are involved in my care where I have granted those care teams access to see my shared data.

**Share-in *Circle Your Choice**

I would* / would-not* like the information recorded at other care teams who are involved in my care to be seen by members of the team at **Sender organisation name**, where I have granted those care teams the right to add to my shared data.

*** Delete as appropriate**

I understand that I can change my decision at any time.

Signed

Patient ……………………………. Date Todays date

OR

Patient representative ……………………

Relationship to patient ……………………