

Selly Oak Health Centre New Patient Health Questionnaire

Date of Birth		Full name	
Occupation		Previous Surnames	
Tel No:	Mobile:	Work:	
Email address:	Consent to contact via: Text: Yes / No Email: Yes / No		

What is your main spoken language?	
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Please list any medications being taken and the dosages:		
Are you registered disabled? If yes , please give details of your disability and any communication need that is related to your disability	Yes	No

Medical Information

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

Have you ever suffered from? (tick as appropriate)							
Epilepsy	Yes	No	Blindness/Glaucoma	Yes	No		
High Blood Pressure	Yes	No	Diabetes	Yes	No		
Heart Attack/Stroke	Yes	No	Depression	Yes	No		
Cancer	Yes	No	Asthma	Yes	No		
Eczema/Hay Fever	Yes	No	Other				

Do you suffer from any allergies? If Yes, pls give details below	Yes		No	
Have you ever refused treatment/screening of any kind, and if so what?	Yes		No	

Do you smoke?	Yes		No		What year did you start smoking?
If no, have you ever smoked?	Yes		No		Quit date:

If **yes** how many cigarettes or ounces of tobacco per week?

Would you like help and advice on giving up smoking?	Yes		No	
How much alcohol do you drink in a week? (If you do not drink, please enter 0 and continue to the family history section)	_____ units			
<i>(1 unit = ½ pint beer, 1 small glass of wine, 1 single spirit, 1 small glass of sherry or 1 single aperitif)</i>				

Alcohol Users Disorders Identification Test (AUDIT) C

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink that contains alcohol?	Never	Monthly or less	2-3 times per month	2-3 times per week	4+ per week	
How many standard 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 standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Family History

Please state any serious illness, in particular heart disease, strokes, cancer, high blood pressure, diabetes or any inherited disease:

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Please give name, relationship, address (if different) and telephone number of next of kin:

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Have you had a flu vaccination? Enter date of most recent or 'never'	
Have you had a pneumococcal vaccination? Enter a date or 'never'	

Do you have a carer?	Yes	Please provide carers details:	No	
Are you a carer?	Yes	Please provide details of person you care for:	No	

Ethnicity:

<input type="checkbox"/> White	British	
	Irish	
	Other (Please specify)	
<input type="checkbox"/> Black	Caribbean	
	African	
	Other (Please specify)	
<input type="checkbox"/> Asian	Indian	
	Pakistani	
	Bangladeshi	
	Chinese	
	Other (Please specify)	
<input type="checkbox"/> Mixed	White & Black Caribbean	
	White & Black African	
	White & Asian	
	Other (Please specify)	

Do you require information in a preferred format?

If yes, please give details: (e.g. large font, BSL, braille).....

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.