

**Kenmore Medical Centre**

60-62 Alderley road, Wilmslow, Cheshire, SK9 1PA

Tel: 01625 532244

 www.kenmoremedicalcentre.co.uk

**New Patient Questionnaire - Adults and Children > 11**

Thank you for applying to join Kenmore Medical Centre. We would like to gather some information about you and ask that you fill in the following questionnaire. You don’t have to supply answers to all of the questions but what you do fill in will help us give you the best possible care. All information provided is kept in strictest confidence and all reasonable precautions taken to prevent unauthorised access. Any information that may identify you is only shared with the practice team or, if referred to hospital, to the clinician who will be treating you. We will only share information about you with anyone else if you give your permission in writing.

Please complete all areas in **CAPITAL LETTERS** and tick the appropriate boxes. Please ensure you **SIGN** and **DATE** your form.

***\*\*YOU ARE REQUIRED TO FILL IN THE FIELDS MARKED WITH AN ASTERISK (\*), FAILURE TO DO SO MAY DELAY YOUR REGISTRATION\*\****

|  |  |  |  |
| --- | --- | --- | --- |
| **\***Title: | \*Surname: |  | **\***First names: |
| **\***Any previous surname(s) (if applicable): |  | **\***Date of Birth: DD / MM / YYYY |
| **\***Home address:\*Postcode: |   | Which of the following best describes how you think of yourself (please tick): [ ]  Male (including trans men) [ ]  Non-Binary  [ ]  Female (including trans woman)  [ ]  In anotherIs your gender identity the same as you were assigned at birth? [ ]  Yes [ ]  No |
| Town and country of birth:  |  | **\***NHS No. [ ] [ ] [ ]  [ ] [ ] [ ]  [ ] [ ] [ ] [ ]  |
| **\***Home telephone No.: |
| Work telephone No.:  |  |  |
| **\***Mobile No. (if you have one):  |  | \*Email address: |
| **Please help us trace your previous medical records by providing the following information** |
| \*Previous address in the UK (if applicable):Postcode: |  | Name of previous doctor: |
| Address of previous doctor: |

**If you are from abroad**

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| --- | --- | --- |
| \*Your first UK address where you registered with a GP if you were previously living abroad:Postcode: |  | \*If previously a resident in the UK, date of leaving: |
| \*Date you first came to live in the UK (if applicable): |

**Are you a Veteran?**

|  |  |  |
| --- | --- | --- |
| Address before enlisting:Postcode: |  | Service or Personnel No.: |
| Enlistment date:Date left the Armed Forces: |

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**Additional details about you**

|  |
| --- |
| What is your ethnic group? **White** [ ]  British [ ]  Irish [ ]  Other White (please specify):**Black** [ ]  Caribbean [ ]  African [ ]  Other Black (please specify):**Asian** [ ]  Indian [ ]  Pakistani [ ]  Chinese [ ]  Other Asian (please specify):**Mixed** [ ]  White + Black Caribbean [ ]  White + African [ ]  White + Asian [ ]  Other mixed:Please advise us of your First Language: **English** [ ]  **Other**  [ ]  (Please state)………………………………………………..Which of the following best describes how you think of yourself (please tick):[ ]  Heterosexual/Straight [ ]  Lesbian/Gay[ ]  Bisexual [ ]  In another way …………………………………. |

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| Height \_\_\_\_\_ Feet \_\_\_\_\_ Inches |  |  Have you had a cervical smear?[ ]  Yes [ ]  No (*Please state where, when and the result if possible*) |
| Weight \_\_\_\_\_ Stone \_\_\_\_\_ Pounds |
| Waist measurement \_\_\_\_\_ Inches |

**Next Of Kin / Emergency contact**

|  |  |
| --- | --- |
| 1 | Name / Relationship to you / Telephone No. / Address (if different to yours) |

|  |  |
| --- | --- |
| 2 | Name / Relationship to you / Telephone No. / Address (if different to yours) |

**Carers Information**

*A carer is a friend / family member who gives their time to support a person in their home, to an extent that the person could not remain at home if this care was not being provided.*

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| **Are you looked after by someone whose support you could not manage without?** [ ]  Yes [ ]  NoIf yes, what is their name and contact number?Do you consent for your carer to be informed about your medical care? [ ]  Yes [ ]  No |

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| **Do you look after or support someone who couldn’t manage without you?** [ ]  Yes [ ]  NoIf yes, do you look after someone who is a patient of Kenmore Medical Centre? [ ]  Yes [ ]  No [ ]  Don’t knowIf yes, what is their name: Are they a [ ]  Friend [ ]  Relative [ ]  Neighbour  |

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| **\***Are you allergic to any medicines? [ ]  Yes [ ]  No (if yes please specify) |

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| **\***List other allergies / intolerances (i.e pollen, animal hair or certain foods. Please mark “none” if you have no other allergies that you know of) : |

**Have you ever had any of the following conditions?**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Epilepsy** | [ ]  Yes  | Year |  | **Rheumatoid Arthritis** | [ ]  Yes  | Year |
| **High Blood Pressure** | [ ]  Yes  | Year |  | **Mental Illness (inc Depression)** | [ ]  Yes  | Year |
| **Heart Attack** | [ ]  Yes  | Year |  | **Diabetes (type 1 or type 2)**Please circle if known | [ ]  Yes  | Year |
| Angina (stable / unstable)Please circle if known | [ ]  Yes  | Year |  | **Asthma** | [ ]  Yes  | Year |
| **Stroke** | [ ]  Yes  | Year |  | **COPD (or Emphysema)** | [ ]  Yes  | Year |
| **Transient Ischaemic Attack** | [ ]  Yes  | Year |  | **Osteoporosis / Bone Fractures** | [ ]  Yes  | Year |
| **Cancer**Specify type: | [ ]  Yes  | Year |  | **Peripheral Vascular Disease** | [ ]  Yes  | Year |

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| List any serious illnesses / operations / accidents / disabilities (women: any pregnancy related problems) & the year they took place: |

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| Do you consider yourself to have a disability? [ ]  Yes [ ]  No**Details of Impairment**Physical impairment [ ]  Learning disability/difficulty [ ]  Sensory impairment [ ]  Mental Health impairment [ ] Other [ ]  (please state)……………………………………………….If you have a sensory impairment, what is your preferred method of communication?................................................................ |

**Communication Preferences**

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| We often contact patients via text message to send appointment reminders, test results and important Practice information. If you **DO NOT** want to be contacted in this way please tick [ ]  If you have stated above you do not want to be contacted by text message please state what is your preferred method in which we can contact you.…………………………………………………………………………………………. |

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| **The Accessible Information Standard (AIS)**Please use this space to tell us about any specific communication needs you have. i.e. needing information in large print or deafblind telephone contact. For further information please visit [**https://www.england.nhs.uk/ourwork/accessibleinfo/**](https://www.england.nhs.uk/ourwork/accessibleinfo/) |

**Do you have Family History of any of the following?**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **High Blood Pressure** | [ ]  Yes  | Who |  | **DVT / Pulmonary Embolism** | [ ]  Yes  | Who |
| **Ischaemic Heart Disease**Diagnosed aged >60 yrs | [ ]  Yes  | Who |  | **Asthma** | [ ]  Yes  | Who |
| **Ischaemic Heart Disease**Diagnosed aged <60 yrs | [ ]  Yes  | Who |  | **Any Cancer**Specify type: | [ ]  Yes  | Who |
| **Raised Cholesterol** | [ ]  Yes  | Who |  | **Thyroid disorder** | [ ]  Yes  | Who |
| **Stroke / CVA** | [ ]  Yes  | Who |  | **Epilepsy** | [ ]  Yes  | Who |
| **Transient Ischaemic Attack** | [ ]  Yes  | Who |  | **Osteoporosis**  | [ ]  Yes | Who |
| **Diabetes** | [ ]  Yes  | Who |  | **Other (please specify)** |  | Who |

**Please tell us about your smoking habits**

|  |  |  |
| --- | --- | --- |
| **\***Do you smoke? [ ]  Yes [ ]  NoIf Yes, what do you primarily smoke:Cigarettes / Cigar / Pipe / Vape **(please circle)**How many do you smoke a day? |  | Are you an ex-smoker [ ]  Yes [ ]  NoWhen did you quit?How many did you used to smoke a day? |
| Would you like advice on quitting? [ ]  Yes [ ]  No |  |  |

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**If you are a student**

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| **MENINGITIS ACWY IMMUNISATION**NHS England strongly recommends anyone who is starting university aged between 18-24yrs have an ACWY booster if you haven’t already done so.[ ]  Yes, I would like a booster (Please contact Reception to book an appointment)[ ]  No, I would not like a booster[ ]  I have already had a Men ACWY booster on (date):…………………………………… |

**Please tell us about your alcohol consumption**

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| **1 Unit** = Normal half pint beer (284ml) 4% *or* Single shot spirit (25ml) 40%. **1.5 Units** = Small glass of wine (125ml) 12.5% *or* Alcopop (275ml) 5.5%.**2 Units** = Strong half pint beer (284ml) 6.5% *or* Medium glass of wine (175ml) 12.5% *or* Normal large bottle/can beer (440ml) 4.5%**3 Units** = Strong bottle/can beer (440ml) 6.5% *or* Bottle of wine (750ml) 12.5% *or* Bottle spirits (750ml) 40% *or* Large glass of wine (250ml) 12.5% |
| **Questions** (please circle your answers in the boxes below) | **Unit scoring system** |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink containing alcohol? | Never | Monthly or less | 2 - 4 timesPer month | 2 - 4 times per week | 4+ times per week |
| How many units of alcohol do you drink on a typical day when you are drinking? | 1 - 2 | 3 – 4 | 5 – 6 | 7 – 9 | 10+ |
| How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| **IF YOU SCORE A TOTAL OF 5 OR MORE ON THE ABOVE QUESTIONS, PLEASE COMPLETE THE FURTHER 7 QUESTIONS BELOW** |
| How often in the last year have you found that you were not able to stop drinking once you had started? | Never | Less thanMonthly | Monthly | Weekly | Daily oralmost daily |
| How often in the last year have you failed to do what was expected of you because of drinking? | Never | Less thanMonthly | Monthly | Weekly | Daily oralmost daily |
| How often in the last year have you needed an alcoholic drink in the morning to get you going? | Never | Less thanMonthly | Monthly | Weekly | Daily oralmost daily |
| How often in the last year have you had a feeling of guilt or regret after drinking? | Never | Less thanMonthly | Monthly | Weekly | Daily oralmost daily |
| How often in the last year have you not been able to remember what happened when drinking the night before? | Never | Less thanMonthly | Monthly | Weekly | Daily oralmost daily |
| Have you or someone else been injured as a result of your drinking? | No |  | Yes but not in the last year |  | Yes during the last year |
| 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 |
| **Your total score for *all ten* questions indicates the following:**0-7 = sensible drinking 8-15 = hazardous drinking **Would you like information or advice about alcohol consumption?**16-19 = harmful drinking 20+ = possible dependence[ ]  Yes [ ]  No |

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| Do you exercise regularly? [ ]  Yes [ ]  No If yes, what exercise do you take and how often: |

**Donor Registration Choices**

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| **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 the boxes that apply.[ ]  Any of my organs and tissue or…[ ]  Kidneys [ ]  Heart [ ]  Liver [ ]  Corneas [ ]  Lungs [ ]  Pancreas**For more information, please visit the website *www.uktransplant.org.uk* or call 0300 123 23 23** |

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**Donor Registration Choices**

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| **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.[ ]  Yes I give consent to be included on the NHS Blood Donor RegisterTick here if you have given blood in the last 3 years [ ] ***For more information, please ask for the leaflet on joining the NHS Blood Donor Register.***My preferred address for donation is: (only if different from above, e.g. your place of work)……………………………………………………………………………………………………………………………………. Postcode: ……………………………………………………… |

**Data Sharing**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Sharing your health record****LOCAL****Cheshire Care Record –** Summary record to help inform your care in Cheshire * Shares a summary of your health and social care record with health and social care professionals involved in your care.
* Helps to support your care.
* Holds GP, hospital, community, social care, mental health and cancer summaries.
* You will be asked to give permission to view your record and can give consent for all staff involved in your care for each consultation.
* If you have you have already told your GP that you don’t want your health data to be shared then a Cheshire care record will not exist for you. If you wish to reconsider and ask your GP to share your data locally, then a Cheshire Care Record can be created for you.
* Alternatively you can inform your GP at any time if you don’t want your information to be shared.

**Cheshire Health Record** – Summary GP data to support your hospital care in Cheshire* Share a summary of your GP patient record with health staff only across Cheshire.
* Holds a summary of your GP record.
* Helps keep your record consistent and up to date.

If you do not want to share your Cheshire Health record there are two options available to you:1. Tell your GP that you wish to opt out completely, so no-one apart from your GP can see your record **even in an a medical emergency.**
2. At the point of treatment you can refuse the health professional access to your record.

**NATIONAL****Summary Care Records** – 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. Having a Summary Care Record can help by providing healthcare staff involved in your care make better and safer decisions about how best to treat you.**You have a 3 options****[ ]  Express consent for medication, allergies and adverse reactions only****[ ] Express consent for medication, allergies, adverse reactions and additional information –** This would include your illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated, what support you might need and who should be contacted for more information about you.**[ ] 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.If no option given a core Summary Care Record (SCR) will be created for you, which will contain only medications, allergies and adverse reactions.Please tick one of the above boxes to indicate your choice and then sign and date below.

|  |  |  |
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| **SIGNED** |  | **DATE** |
| **PRINT NAME** |  |  |

**YOUR DATA MATTERS****From 25th May 2018 you can choose to stop your confidential patient information being used for purposes other than your care and treatment. This choice is known as national opt-out.****If you have previously registered an opt-out with your GP Practice to request that NHS Digital does not use your confidential patient information , this will have automatically been converted to a national data-opt out on 25th May 2018.****OR** patients can view or change their National data opt-out choice at any time by using the online service at www.nhs.uk/your-nhs-data-matters-. |

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**Online Patient Access**

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| Once your application to join our practice has been accepted you’ll be able to order your repeat medications, book appointments and view certain aspects of your medical record online. This service is known as **Patient Access**. To register visit our website **www.kenmoremedicalcentre.co.uk** or ask reception for an **application form**. You’ll need to bring your completed form to reception with **photographic ID and proof address** (under 16 year olds are exempt from ID). You’ll be emailed a registration letter within **seven working days**. You’ll use this letter to create your online account. Please note ***you must have an email address to use this service*** ***and given consent to receive emails from Kenmore Medical Centre***. Full terms and conditions are available on the application form. |

**Once you are registered…**

Electronic Prescription Service (EPS)

… You will be able to nominate a pharmacy to collect your prescriptions from. EPS enables prescribers, such as GP’s and practice nurses, to send prescriptions electronically to a pharmacy of the patient’s choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff. If you have already nominated a pharmacy, please tell us which pharmacy you have chosen. For further information about this service please talk to your pharmacist of choice.

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| --- |
| **Please record any additional information about you that you think is important for us to know on a separate sheet of paper and attached to this registration form.** |

|  |  |  |
| --- | --- | --- |
| **\*Signed** |  | **\*Date** DD / MM / YYYY |

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| **Signed on behalf of patient** (*if applicable*) (e.g. for adults lacking capacity) |

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| **SUPPLEMENTARY QUESTIONS** |
| **PATIENT DECLARATION for all patients who are not ordinarily resident in the UK** |
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| Anybody in England can register with a GP practice and receive free medical care from that practice.However, if you are not ‘ordinarily resident’ in the UK you may have to pay for NHS treatment outside of the GP practice. Being ordinarily resident broadly means living lawfully in the UK on a properly settled basis for the time being. In most cases, nationals of countries outside the European Economic Area must also have the status of ‘indefinite leave to remain’ in the UK. Some services, such as diagnostic tests of suspected infectious diseases and any treatment of those diseases are free of charge to all people, while some groups who are not ordinarily resident here are exempt from all treatment charges. More information on ordinary residence, exemptions and paying for NHS services can be found in the Visitor and Migrant patient leaflet, available from your GP practice.**You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment. Even if you have to pay for a service, you will always be provided with any immediately necessary or urgent treatment, regardless of advance payment.****The information you give on this form will be used to assist in identifying your chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitals) and NHS Digital, for the purposes of validation, invoicing and cost recovery. You may be contacted on behalf of the NHS to confirm any details you have provided.****Please tick one of the following boxes:**a) [ ]  I understand that I may need to pay for NHS treatment outside of the GP practice b) [ ]  I understand I have a valid exemption from paying for NHS treatment outside of the GP practice. This includes for example, an EHIC, or payment of the Immigration Health Charge (“the Surcharge”), when accompanied by a valid visa. I can provide documents to support this when requestedc) [ ]  I do not know my chargeable statusI declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.**A parent/guardian should complete the form on behalf of a child under 16.** |

 |
| **\*Signed:** |  | **\*Date:** | **DD / MM / YYYY** |
| **\*Print name:** |  | **\*Relationship**  **to patient:** |  |
| **\*On behalf of:** |  |

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| **Complete this section if you live in another EEA country, or have moved to the UK to study or retire, or if you live in the UK but work in another EEA member state. Do not complete this section if you have an EHIC issued by the UK.** |
|  |
| **NON-UK EUROPEAN HEALTH INSURANCE CARD (EHIC), PROVISIONAL REPLACEMENT CERTIFICATE (PRC)DETAILS and S1 FORMS** |
|  |
| **Do you have a non-UK EHIC or PRC?** | [ ]  Yes [ ]  No | **If yes, please enter details from your EHIC or PRC below:** |
| *If you are visiting from another EEA* *Country and do not hold a current EHIC (or Provisional Replacement Certificate (PRC))/S1, you may be billed for the cost of any treatment received outside of the GP practice, including at a hospital.* | **Country Code:**   |  |
| **3: Name** |  |
| **4: Given Names** |  |
| **5: Date of Birth** | **DD / MM / YYYY** |
| **6: Personal Identification****Number** |  |
| **7: Identification number****of the institution** |  |
| **8: Identification number of the card** |  |
| **9: Expiry Date** | **DD / MM / YYYY** |
| **PRC validity period (a) From:** | **DD / MM / YYYY** | **(b) To:**  | **DD / MM / YYYY** |
| Please tick [ ]  if you have an S1 (e.g. you are retiring to the UK or you have been posted here by your employer for work or you live in the UK but work in another EEA member state). **Please give your S1 form to the practice staff.** |
| **How will your EHIC/PRC/S1 data be used?** By using your EHIC or PRC for NHS treatment costs your EHIC or PRC data and GP appointment data will be shared with NHS secondary care (hospitals) and NHS Digital solely for the purposes of cost recovery. Your clinical data will not be shared in the cost recovery process.Your EHIC, PRC or S1 information will be shared with The Department for Work and Pensions for the purpose of recovering your NHS costs from your home country. |

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