This questionnaire is to help us gather information regarding whilst we are waiting for your full medical record to be received from your previous Doctor**.** **PLEASE ENSURE ALL SECTIONS ARE COMPLETE** This will help the transfer run as smoothly as possible.

Please complete in **BLOCK CAPITALS** and tick relevant boxes.

* Please complete a separate form for each adult registering
* When handing this form, it would be helpful if you could bring photo ID & proof of address
* In order to provide care and ensure safety we may need to share information with other healthcare professionals. If you have any concerns regarding this, please speak to the Practice Manager

**Registration Details**

All questions marked (\*) are required by the surgery to complete the registration (please complete one registration form for each person)

|  |  |
| --- | --- |
| Title\* |  |
| Pronouns |  |
| Surname\* |  |
| Previous Surname\* |  |
| Forenames\* |  |
| Date of birth\* |  |
| Town of birth\* |  |
| Country of birth\* |  |
| NHS No. |  |
| Home address\* |  |
| Home telephone number\* |  |
| Mobile telephone number\* |  |
| Email Address\* |  |

**Ethnicity**

What is your ethnic group? Please tick one box that best describes your ethnic group or background from the options below:

|  |
| --- |
| **White**: British Irish Irish Traveller Traveller Gypsy/Romany Polish 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 Somali Nigerian Any other Black background (please write in): |
| **Another ethnic group:** Chinese Filipino Any other ethnic group (please write in): |
| **Not stated:** Not Stated should be used where the PERSON has been given the opportunity to state their ETHNIC CATEGORY but chose not to. |

**Gender**

What is your current gender identity (Please tick one)\*

|  |  |  |
| --- | --- | --- |
|  | | Male |
|  | | Female |
|  | | Transgender Male/Trans Man/Female-to-Male (FTM) |
|  | | Transgender Female/Trans Woman/Male-to-Female (MTF) |
|  | | Genderqueer, neither exclusively male nor female |
|  | | Additional Gender Category/ (or Other), please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | | Choose not to disclose |
| What Sex were you assigned at Birth on your original Certificate (Please tick one) \* | | |
|  | Male | |
|  | Female | |
|  | Choose not to disclose | |

**Next of Kin and Emergency Contact Details**

|  |  |
| --- | --- |
| Name\* |  |
| Contact number\* |  |

To help us trace your previous medical records please provide the following information

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Previous address in the UK\* | | |  | |
| Name of Previous GP Practice\* | | |  | |
| Is this your first NHS registration in England? \* | | | Y/N  If yes, what date did  you enter the UK? | |
| Please indicate if you have served in the UK Armed Forces and/or been registered with a Ministry of Defence GP in the UK or overseas: | | | | |
| Regular |  | Reservist | |  |
| Veteran |  | Family Member (Spouse, Civil Partner, Service Child) | |  |

**Communication and Accessibility Needs**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do you have any communication requirements? | | | | |
| Sign Language |  |  | Large Print |  |
| Interpreter | (Language required) | | | |
| Other (please specify) |  | | | |

**Medical Questionnaire**

Please take the time to complete this document as this information helps us to know more about you as your record will not reach us immediately.

**Measurements**

|  |  |
| --- | --- |
| Height |  |
| Weight |  |
| Waist measurement |  |
| Blood Pressure Reading |  |

**Personal Medical History** (if you require more space, please use a separate sheet)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Have **you** suffered or are currently suffering with any of the following (please tick all that apply) | | | | | | |
|  | | Year Diagnosed | |  | | Year  Diagnosed |
| Blindness/Glaucoma | |  |  | | Epilepsy |  |
| High Blood Pressure | |  | Heart Attack |  |
| Diabetes | |  | Stroke/CVA |  |
| Asthma/COPD | |  | Cancer (where) |  |
| Other (please specify) |  | | | | | |

**Family Medical History** (if you require more space, please use a separate sheet)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Has any **close relative** suffered or are currently suffering with any of the following (please tick all that apply) | | | | | | |
|  | | Year Diagnosed |  | | | Year Diagnosed |
| Blindness/Glaucoma |  |  |  | Epilepsy |  |  |
| High Blood Pressure |  |  | Heart Attack |  |  |
| Diabetes |  |  | Stroke |  |  |
| Asthma/COPD |  |  | Cancer |  |  |
| Other (please specify) |  | | | | | |

**Medication**

If you take any repeat medications, please provide a copy of your repeat medication slip or complete the table below (if you require more space, please use a separate sheet).

|  |  |  |
| --- | --- | --- |
| Name of Medication | Strength | Dosage |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Care at Home**

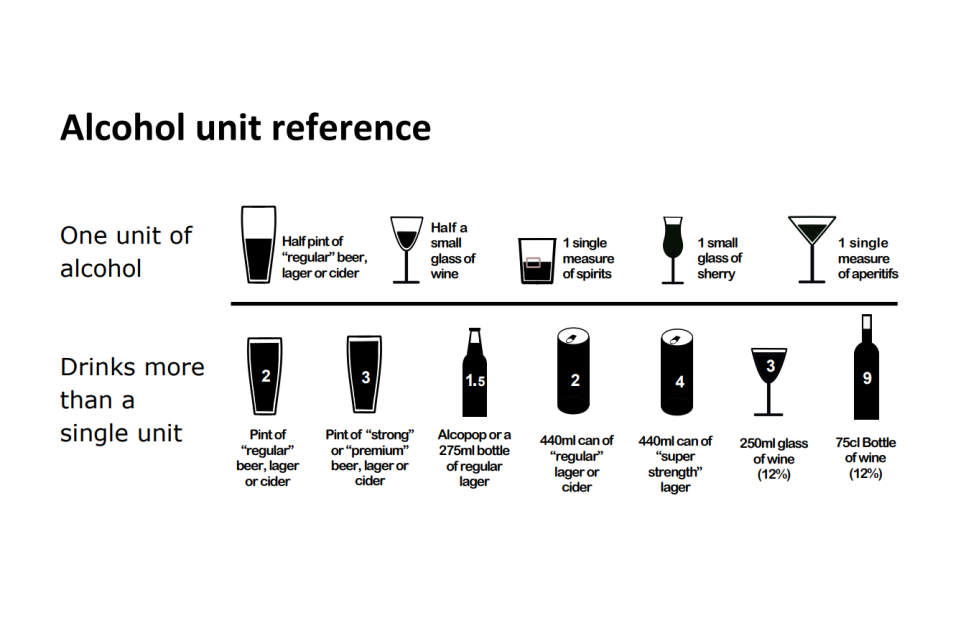
|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Please tick all that apply to you | | | | | | |
| Are you a carer?  If yes, who do you care for? | Y/N | | |  | Do you have a carer?  If yes, who is your Carer? | Y/N |
| Are you housebound? |  | | | Are you registered disabled? |  |
| Do you have a keypad number? |  | | | Do you have a Power of Attorney in place? |  |
| Please provide relevant details about items you have ticked above |  | | | | | |
| Do you feel lonely or isolated? | Yes | No |  | | | |
| If Yes, Would you like Support with this? |  |  | **OFFICE USE ONLY:** If yes please contact  Social Prescribing Link Worker for SHS | | | |

**Smoking**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Please answer Yes or No | | | | | |
| Have you ever smoked? |  | | If yes, please answer the following questions. If no, please move to the next section. | | |
| Do you smoke now? |  | |  | If yes how many cigarettes or grams of tobacco do you smoke each day? |  |
| If no, when did you quit? |  |
| If you would like help to stop smoking, Smokefreelife Somerset offer a free service [www.healthysomerset.co.uk/smokefree/](http://www.healthysomerset.co.uk/smokefree/)  Or call 01823 356222 | | For more information: -  <https://www.nhs.uk/live-well/quit-smoking/nhs-stop-smoking-services-help-you-quit/> | | | |

**Exercise**

|  |  |  |  |
| --- | --- | --- | --- |
| How many times a week do you exercise for 30 minutes or more? |  | Is this exercise light, moderate or vigorous? |  |

**Alcohol**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Question** | **Scoring System** | | | | | **Your Score** |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink containing alcohol? | Never | Monthly or less | 2 to 4 times per month | 2 to 3 times per week | 4 times or more per week |  |
| How many units of alcohol do you drink on a typical day when you are drinking? | 0 to | 2 3 to 4 | 5 to 6 | 7 to 9 | 10 or more |  |
| 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 |  |
| How often during the last year have you found that you were not able to stop drinking once you had started? | 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 from you because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you had a feeling of guilt or remorse after drinking? | 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 |  |
| Have you or somebody 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 |  |
| **Total score** | | | | | |  |

Scoring:

0 to 7 indicates low risk 8 to 15 indicates increasing risk

16 to 19 indicates higher risk 20 or more indicates possible dependence

**Please select the following to indicate preferences for us keeping in touch with you**

|  |  |
| --- | --- |
| Consent to receiving information by email: (enter email) | Yes/No |
| Consent to receiving information by phone: (enter number) | Yes/No |
| Consent to being contacted via text: (enter number) | Yes/No |
| I consent to messages being left with a spouse/family member | Yes/No |
| I would like to receive text appointment reminders | Yes/No |
| I would like to receive email appointment reminders | Yes/No |
| I would like to receive email appointment reminders | Yes/No |
| I would like to receive important practice announcements and promotions | Yes/No |

**Summary Care Record System**

The NHS Summary Care Record provides a snapshot of some important information:

* **Any allergies you may have,**
* **Unexpected reactions to medications**
* **And any prescriptions you have recently received.**

The Summary Care Record can only be accessed by authorised clinicians and even then, only if you give permission. Across England it is helping clinicians in Accident and Emergency Departments and ‘Out of Hours’ health services to give you safe, timely and effective treatment. If you go into hospital, the pharmacy there would be able to check the information above to ensure safe medication for you. You will be asked if healthcare staff can look at your Summary Care Record every time they need to, unless it is an emergency, for instance if you are unconscious.

You can change your Summary Care record choice at any time by contacting us at the Surgery.

You are strongly recommended to consider this choice to enhance your care. Please tick the box below to show your preference and return it to Reception with your registration forms.

Yes, I want a Summary Care Record  No I do not want a Summary Care Record

Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children under the age of 16

Patients under 16 years will not receive this form but will have a Summary Care Record created for them and be opted in to care. Data unless their GP surgery is advised otherwise. If you are the parent or guardian of a child, then please either make this information available to them or decide and act on their behalf. Ask the surgery for additional forms if you decide that they should not have a Summary Care Record or need to opt out of the care. Data scheme.

**Practice Processes**

* The practice uses the Ask My GP online triage system whereby you can submit a request for a telephone call, appointment or message from the clinical team here without even needing to pick up the phone. For more information, go to [www.exmoormedicalcentre.co.uk/askmygp](http://www.exmoormedicalcentre.co.uk/askmygp) or speak to one of the Reception Team.
* Our phone lines are open between 8.30am and 6.00pm Monday to Friday for appointment requests and enquiries.
* We are a Dispensing practice meaning that if you live more than a mile away from a pharmacy, you can collect your medication from the practice. We also provide a free home delivery service if required – please speak to the Dispensary Team for more details.
* We only accept repeat medication/prescription requests by telephone between 10am-12pm Monday to Friday. However, you can request your medications via the NHS App or the Patient Access Website 24 hours a day, 7 days a week.
* The NHS App also displays your vaccination record.
* Please see the practice website for more details and information about the surgery [www.exmoormedicalcentre.co.uk](http://www.exmoormedicalcentre.co.uk)

**How Your Data is Used**

* Your summary care record is an electronic record of your valuable information about your health. This data is shared between healthcare providers to enable treatment in the case of emergency. For more information or if you would like to opt out, please follow the link below

<https://digital.nhs.uk/services/summary-care-records-scr/summary-care-records-scr-information-for-patients>

* GP data collection is how NHS digital extracts anonymised data to support healthcare service through planning and research. For more information or if you would like to opt out, please follow the link below

[National data opt-out - NHS Digital](https://digital.nhs.uk/services/national-data-opt-out)

**By submitting this form to Exmoor Medical Centre, you agree:**

|  |
| --- |
| That you may be contacted from time to time, via email and/or SMS with practice news, advice, about your health and/or appointment reminders.  I have read and understood the above questions and am happy for the practice to contact me regarding the information I have submitted.  Signature……………………………………………………………  Printed Name…………………………………………………….  Date………………………………………………………………….. |