Castlehead Medical Centre

NHS
North Cumbria
Clinical Commissioning Group

NEW PATIENT QUESTIONNAIRE (16 and over)

Please complete as many questions as you can. The information will help the practice to provide better medical care for you. This information will be held in the strictest confidence as per Data Protection.
(For our data protection policies please see www.castlehead.org.uk)

All new patients who have repeat medications only need to make a 10 minute appointment to see the GP
All new patients over 16 years old and who are not on any repeat medication need a 20 minute appointment with the Health Care Assistant.

Your registered GP will be one of the following: Dr T Hooper, Dr P Hemingway, Dr C Ferris, Dr C Haslam, Dr D Brigham, Dr J Whittaker, Dr J Conlon or Dr J Stapleton

Surname: ..... First Name: ..... Maiden name: .....

Date of Birth: .....

Current Address: .....

.....

.....

.....

Postcode: .....

Tel. No: ..... Mobile No: .....

Email Address: .....

1. Contact Permission

We like to keep or patient informed on events in practice and any changes/additional services that we introduce. We keep our patient informed via our practice Newsletter and Patient Participation Group and would like to include you in our email circulation. We treat personal details as confidential and follow all data protection process. We will only use patient contact details for medical reasons, including sending updates regarding booked appointment or practice updates where permission has been given.

Yes please contact me with practice updates ☐ No thank you, I do not want you to send me updates ☐
Do you consent to being contacted via: Telephone ☐ Mobile ☐ Email ☐

Please turn over

Marital Status:Single/Married/Separated/Divorced/Widowed/Other .....

Occupation: .....

Height: .....m/ft Weight: .....kg/st

Ethnic Origin: ..... First Language: ..... Interpreter required? Yes/No

Refugee – If Yes, from which country? .....

Which of the following options best describes how you think of yourself?

Woman (including trans woman) ☐ Man (including trans man) ☐ Non-binary ☐

In another way (pleases state): .....

Is your gender identity the same as the one you were given at birth?

Yes ☐ No ☐

Which of the following options best describes how you think of yourself?

Lesbian ☐ Bisexual ☐ Gay ☐ Heterosexual/Straight ☐ In another way (pleases state):

.....

2. Previous Doctor

Name: .....

Address: .....

.....

..... Postcode: .....

3. Next of Kin

Name: ..... Contact No: .....

Relationship: .....

4. Personal Medical History

Please list serious or chronic illnesses, operations, or disabilities:		
Year:	**Have you ever needed treatment for:**	
	Epilepsy / fits	Yes No

Please turn over

	Blindness / Glaucoma	Yes No
	Blood Pressure (hypertension)	Yes No
	Diabetes	Yes No
	Stroke or TIA	Yes No
	Heart Attacks	Yes No
	Asthma	Yes No
	Cancer	Yes No
	Depression	Yes No
	Mental Health Problem	Yes No
	Kidney Disease	Yes No
	Dementia	Yes No
	COPD (Bronchitis or Emphysema)	Yes No
	Thyroid Problem	Yes No
	History of Fractures	Yes No
	Osteoporosis	Yes No
	Rheumatoid Arthritis	Yes No
	Any history of Operation or procedure? If Yes please state what?	Yes No

5. Medical History Of Family – (brothers, sisters, parents, uncles, aunts, grandparents)

Has any close relative suffered from the following:		**(Please note if it was before the age of 60):**
Blood Pressure (hypertension)	Y N	
Heart Attack or Angina	Y N	
Diabetes	Y N	
Stroke or TIA	Y N	
Cancer	Y N	

6. Social History

1. Do you live alone? Yes/No
2. Are you homeless? Yes/No
3. Are you Housebound? Yes/No
4. Do you have a carer? Yes/No

Name of Carer: ..... Relationship: ..... Tel. No: .....

Do you consent to us contacting your carer? Yes/No
5. Are you a carer for a relative or friend? Yes/No
6. Are you a care leaver? Yes/No
7. Have you ever or are you currently serving in the Armed Forces? Yes/No
8. Do you have a Social Worker? Yes/No

What is their name/contact details?.....

7. Disability, Age Related Problems or Special Needs

Are you registered disabled? Yes/No

Please turn over

Do you have any problems with:		
Vision	Y	N
Speech	Y	N
Mobility	Y	N
Hearing	Y	N
Learning Difficulties	Y	N
Autism	Y	N

8. Reasonable Adjustments

What help do you need to see the nurse or doctor – e.g. longer appointments/ appointment at a quieter time?

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9. Lifestyle

Please circle which diet you follow: Vegetarian/Vegan/Weight Reducing/Low Fat/Low Salt/High Fibre/ Dairy Free/Diabetic/Gluten Free /Normal/Other

Do you smoke? Yes/No

Cigarettes: ..... per day Cigars: ..... per day Pipe: ..... ozs per week Tobacco: ..... ozs per week

Have you ever smoked? Yes/No If yes, when did you stop? .....

If you do smoke, do you wish to discuss stopping smoking? Yes/No

Do you drink alcohol? Yes/No How much?: ..... units per week

Questions	0	1	2	3	4	Your Score
How often do you have a drink that contains alcohol	Never	Monthly of less	2-4 times per month	2-3 times per week	4+times 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 -9	10+	
How often do you have 6 or more standard drinks on one occasion	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Do you feel you need support with your drug/alcohol intake? Yes/No

Please turn over

10. Exercise

Do you undertake any regular sport or exercise? Yes/No

Daily/2-3 Times a Week/Weekly/Occasionally

What exercise do you do? .....

11. Blood Pressure

Have you ever had your **BLOOD PRESSURE** tested? Yes/No

If so, when? .....

Has it even been **HIGH**? Yes/No

12. Drugs & Medicines

Are you taking any drugs, medicines, tablets or contraceptive pills? Yes/No

If so, which one(s)? Name of Medicine/Dosage:

.....

.....

Please provide a printout of your medication if you need it on a regular basis

Are you able to manage your medication yourself? Yes/No

If No – what help do you need? .....

13. Allergies

Please list any medicines, foods, plants or animals to which you think you are allergic:

.....

14. Vaccinations

When was your last:

Diptheria/Tetanus/Polio: .....

Influenza: .....

Pneumonia: .....

Any Travel Immunisations? .....

Please turn over

15. Only answer the questions relevant to you

Have you/do you attend a family planning clinic? Yes/No
Do you take a contraceptive pill/injection? Yes/No
Which one? .....
How long have you been taking the pill/injection? .....
Are you fitted with a coil? Yes/No
When was it fitted? .....
Have you ever had a cervical smear? Yes/No
If Yes, date of last one: .....
Result of cervical smear: .....
Have you ever been pregnant? Yes/No
If yes: a) How many children do you have? .....
b) Have you had any miscarriages? Yes/No
Have you been immunised against Rubella? Yes/No

16. Screening:

Have you had Cervical/Breast/Chest/Bowel Screening in the last 5 years?
Type of Screening: _____ Date of Screening: _____Result: _____
Type of Screening: _____ Date of Screening: _____Result: _____
Type of Screening: _____ Date of Screening: _____Result: _____

Please include any additional information that the GP practice can help you with

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17. Summary Care Record Sharing

Do you object to your summary care record being available when you access NHS care outside of your GP Practice (for example NHS Out of Hours Services or Accident & Emergency)? (Please see the information leaflet overleaf)

By signing this form you have consented to a Summary Care Record being created for your emergency care, please see the enclosed letter for details. If you wish to Opt Out of this please ask for the relevant form.

If you wish to Opt Out of the sharing of your GP records to the Health and Social Care Information Centre, via the General Practice Extraction Service, or to learn more about this, please visit www.nhs.uk/your-nhs-data-matters or telephone 0300 3035678

Today's Date: ..... Signature: .....

Please turn over

Your emergency care summary

Summary Care Record – your emergency care summary

The NHS in England is introducing the Summary Care Record, which will be used in emergency care.

The record will contain information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had to ensure those caring for you have enough information to treat you safely.

Your Summary Care Record will be available to authorised healthcare staff providing your care anywhere in England, but they will ask your permission before they look at it. This means that if you have an accident or become ill, healthcare staff treating you will have immediate access to important information about your health.

Your GP practice is supporting Summary Care Records and as a patient you have a choice:

Yes, I would like a Summary Care Record – you do not need to do anything and a Summary Care Record will be created for you.

No, I do not want a Summary Care Record –. Please ask GP practice staff for an 'opt out' form, complete the form and hand it to a member of the GP practice staff.

If you need more time to make your choice you should let your GP Practice know.

For more information talk to our Patient Advice and Liaison Service (PALS) **(01228 602128.),** GP practice staff, or **www.nhscarerecords.nhs.uk** or telephone the dedicated NHS Summary Care Record Information Line on 0300 123 3020.

Additional copies of the opt out form can be collected from the GP practice, printed from the website **www.nhscarerecords.nhs.uk** or requested from the dedicated NHS Summary Care Record Information Line on 0300 123 3020.

You can choose not to have a Summary Care Record and you can change your mind at any time by informing your GP practice.

If you do nothing we will assume that you are happy with these changes and create a Summary Care Record for you. Children under 16 will automatically have a Summary Care Record created for them unless their parent or guardian chooses to opt them out.
If you are the parent or guardian of a child under 16 and feel that they are old enough to understand, then you should make this information available to them.

Please turn over

18. Prescriptions

If you are taking medication we can send your prescription to a nominated pharmacy for you, or if you live a mile away from a pharmacy you can use our own dispensing facilities. Reception and dispensary staff will be able to advise you if we are able to dispense to you.

It would help us to process your prescription more efficiently if you could please nominate a pharmacy or our own dispensary by indicating below where you would like to collect future prescriptions from (this can be changed at any time by asking our dispensary staff to arrange this for you).

You can order repeat prescriptions in any of the following ways:

- Order via Emis Access on our website www.castlehead.org.uk, after you have registered to access this facility.
- Order via MyGP App on your mobile device, after you have registered to access this facility.
- Complete the 'White Slip' given to you by your pharmacy which shows the list of drugs that you can order as a repeat issue. Please ONLY tick the items that you need on the white slip. Please DO NOT tick items that are not required. Within 5 days of running out of your medication you can hand this slip into your nominated pharmacy for them to deliver to the Medical Centre or you can deliver it to the Medical Centre in person.
- Call our dedicated repeat prescription line on 017687 80125. Please don't call the main dispensary line to order prescriptions, as this is for urgent queries only.

If you wish to use online facilities please contact the medical centre to obtain your extended online access.

Please allow at least 96 working hours excluding weekends and Bank Holidays before collection.

.....✂.....

Please take the completed form to the dispensary

Pharmacy / Dispensary Nomination

Name .....

Date of Birth .....

Address .....

Castlehead Medical Centre Dispensary	
Boots, Main Street, Keswick	
Cohens Pharmacy, Station Street, Keswick	

Other ..... Signature.....

Action	Actioned	Date	Action	Actioned		Date
New prescription destination added			Informed about electronic repeat dispensing	Yes	No	
Old nomination removed						
Nominated for EPS prescriptions						

NOTES:

Please turn over

19. Consent to discuss my medical information (including 13-16 year olds)

(Patient name).....date of birth.....

of address.....

Give my consent to Castlehead Medical Centre to provide my personal medical information to the nominated person(s) named below which must be adequate, relevant not excessive and accurate:

1. Consent given to (name).....

Relationship to me.....

Tel contact Home.....Mobile.....

Signature (of nominated person).....Date.....
By signing this you are agreeing that you give consent for Castlehead medical centre to hold your personal data until this consent is withdrawn by either party.

2. Consent given to (name).....

Relationship to me.....

Tel contact Home.....Mobile.....

Signature (of nominated person).....Date.....
By signing this you are agreeing that you give consent for Castlehead medical centre to hold your personal data until this consent is withdrawn by either party.

If you would like to add any exclusion to this, please list these below, otherwise we will accept this as consent given to discuss or disclose anything in your medical records.

Items to be excluded: .....

.....

I understand that this consent form will remain in place until I give written advice to Castlehead Medical Centre to have this withdrawn and I accept that it is my responsibility.

Signed.....Date.....

Office use only	Date	Initial
Alert added to patient record, including contact tel numbers of 3rd party		
Code added 9NdG		

Please turn over

For Internal Use Only:

Patients are requested to present 2 forms of I.D. (one being a photograph)
Please tick I.D. checked:

Utility bill / Driving License / Passport / Bus pass / Student I.D. / Other (Please specify)

Date: .....

For Reception Checklist Use Only	
• **Form checked and fully completed**	**Yes / No**
• **GMS1 form received and checked** *Add to EMIS asap*	**Yes / No**
• **Practice Leaflet given**	**Yes / No**
• **ID checked**	**Yes / No – Detail.....**
• **Named GP**	**DR.....**
• **Verbal Invite for Health Check**	**Yes / No / Not applicable**
• **Health check booked**	**Date.....**
• **Dispensing patient - YES / NO**	**NO - Chemist Location .....**
• **Checked for safeguarding vulnerability**	**Yes/No**
Date.....	**Receptionist's Signature:** **.....**

Please turn over

For Office Use Only	
• GP2GP	Yes / No
• NOK added	Yes / No
• Appts added/confirmed on EMIS	Yes / No
• Registration New Patient template completed on EMIS	Yes / No
• SCR consent updated 'Opt in' code 9NUB	Yes / No
• New patient spreadsheet updated	Yes / No
• Dispensary status and location	Yes / No
• Reasonable adjustment	Yes / No

Please turn over