

Thank you for applying to join Hazelmere 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. **Please supply two forms of identification with your completed form, a photographic form of ID (such as passport or driving license) and proof of your home address (such as a recent bank statement or document relating to your new home).**

Please complete all areas in **CAPITAL LETTERS** and tick the appropriate boxes.

Fields marked with an asterix (\*) are mandatory.

*Title	*Surname
*Any previous surname(s)	
* <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intermediate <input type="checkbox"/> Unspecified	
Town and country of birth	
Home telephone No.	Preferred Number <input type="checkbox"/> Yes <input type="checkbox"/> No
Work telephone No.	Preferred Number <input type="checkbox"/> Yes <input type="checkbox"/> No
Mobile No.	Preferred Number <input type="checkbox"/> Yes <input type="checkbox"/> No

*First names
*Date of Birth
*NHS No. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
*Home address & Postcode
*Previous address & Postcode
Email address

*Previous GP Details
<b>(for women only)</b> Have you had a cervical smear? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(Please state where, when and the result if possible)</i>

If you are from abroad please tell us your first UK address where registered with a GP:
If previously resident in UK, date of leaving:
Date you first came to live in UK:
Marital Status? <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed

### Additional details about you

What is your ethnic group?					
<b>White</b>	<input type="checkbox"/>	British	<input type="checkbox"/>	Irish	
<b>Black</b>	<input type="checkbox"/>	Caribbean	<input type="checkbox"/>	African	
<b>Asian</b>	<input type="checkbox"/>	Indian	<input type="checkbox"/>	Pakistani	<input type="checkbox"/> Chinese
<b>Mixed</b>	<input type="checkbox"/>	White + Black Caribbean	<input type="checkbox"/>	White + African	<input type="checkbox"/> White + Asian
<b>Other</b>	<input type="checkbox"/>	Please specify:			

Main Language Spoken? (E.g. English)
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Have you ever been in the employ of the Armed Forces?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Personnel Number:</b>	<b>Date Enlisted:</b>
<b>Are you a dependant of a current serving member of British Armed Forces?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

### Next of kin \ Emergency contact

Name of next of kin \ Emergency contact
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Relationship to you
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Next of kin \ Emergency contact telephone number(s)
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Next of kin \ Emergency contact address (if different to above)
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## Data Sharing

### Enhanced Data Sharing Module (EDSM)

Hazelmere Medical Centre use a clinical computer system called SystmOne to record your medical information. With your consent, you can allow your full GP record to be shared with other healthcare services that are providing care for you and who also use SystmOne. These other services will always ask consent to view your record.

Tick this box if you wish to opt-out of the enhanced data sharing module

### Medical Interoperability Gateway (MIG)

The MIG enables secure sharing of relevant medical information from your GP record with other healthcare professionals who are providing you with direct care, even if they are not using the same electronic records system. At point of care you will be asked if you consent to the care service seeing essential elements of your record.

More information can be found by visiting: <http://www.healthcaregateway.co.uk/products>

Tick this box if you wish to opt-out of the MIG data sharing

### Risk Stratification Preferences

**Risk stratification** is the process of identifying the relative **risk** of patients in a population by analysing their medical history. It's a key enabler for improving the quality of care delivered by the NHS. Hazelmere Medical Centre is taking part in the Risk Stratification programme and will be uploading patient identifiable data for analysis. Patient identifiable information will only be viewable at GP practice level. Any NHS organisation external to the practice using risk stratification will only see anonymised data.

Tick this box if you wish to opt-out of the Risk Stratification programme

\*Do you consent to receive the following types of communication (if offered) from Hazelmere Medical Centre?

Email  Yes  No

Mobile phone text messages  Yes  No

Answering machine messages  Yes  No

## Carers Information

*A carer is a friend or 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. A carer can receive Carers Allowance, but not a wage and the care they are giving will significantly affect their own life.*

Are you looked after by someone who's support you could not manage without?  Yes  No

If yes, what is their name and contact number?

Do you consent for your carer to be informed about your medical care?  Yes  No

Do you look after or support someone who couldn't manage without you?  Yes  No

If yes, do you look after someone who is a patient of Hazelmere Medical Centre?  Yes  No  Don't know

If yes, what is their name?

Are they a:  Relative  Friend  Neighbour

## Medical details

**In order to continue to receive your repeat medications you'll need to make a new patient health check appointment and bring in your last repeat prescription. (Please note, certain medications will require an appointment with the GP before they can be prescribed) Please allow plenty of time to organise repeats. Please provide us with your repeat medication list found on the right hand side or a printed prescription.**

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

\*List other allergies / intolerances (i.e. nuts, gluten, 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?

<b>Epilepsy</b>	<input type="checkbox"/> Yes	Year
<b>High Blood Pressure</b>	<input type="checkbox"/> Yes	Year
<b>Heart Attack / Angina</b>	<input type="checkbox"/> Yes	Year
<b>Stroke / Mini-stroke (TIA)</b>	<input type="checkbox"/> Yes	Year
<b>Cancer</b>	<input type="checkbox"/> Yes	Year
<b>Rheumatoid Arthritis</b>	<input type="checkbox"/> Yes	Year

<b>Mental Illness</b>	<input type="checkbox"/> Yes	Year
<b>Diabetes</b>	<input type="checkbox"/> Yes	Year
<b>Asthma</b>	<input type="checkbox"/> Yes	Year
<b>COPD (or Emphysema)</b>	<input type="checkbox"/> Yes	Year
<b>Osteoporosis / Bone fractures</b>	<input type="checkbox"/> Yes	Year
<b>Peripheral vascular disease</b>	<input type="checkbox"/> Yes	Year

Do you have any disabilities, illnesses or accessibility needs? I.e. needing to be seen in ground floor consulting rooms or use of a specific communication device such as a hearing aid? If yes, please tell us how we can support your needs.

### 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/>

### Do you have family history of any of the following?

<b>High Blood Pressure</b>	<input type="checkbox"/> Yes	Who
<b>Ischaemic Heart Disease</b> Diagnosed aged >60 yrs	<input type="checkbox"/> Yes	Who
<b>Ischaemic Heart Disease</b> Diagnosed aged <60 yrs	<input type="checkbox"/> Yes	Who
<b>Raised Cholesterol</b>	<input type="checkbox"/> Yes	Who
<b>Stroke / CVA</b>	<input type="checkbox"/> Yes	Who
<b>Asthma</b>	<input type="checkbox"/> Yes	Who

<b>DVT / Pulmonary Embolism</b>	<input type="checkbox"/> Yes	Who
<b>Breast Cancer</b>	<input type="checkbox"/> Yes	Who
<b>Any Cancer</b> Specify type:	<input type="checkbox"/> Yes	Who
<b>Thyroid disorder</b>	<input type="checkbox"/> Yes	Who
<b>Epilepsy</b>	<input type="checkbox"/> Yes	Who
<b>Osteoporosis</b>	<input type="checkbox"/> Yes	Who

### Looked After Children

Are you looking after someone else's child?  Yes  No  
 If Yes, under what arrangements:  
 Section 20-Voluntary Care  Interim Care Order  Care Order  
 Child arrangement order/Residence Order  Special Guardianship order  
 Placed for adoption  
 Private arrangement/Private Fostering/informal arrangement  
 (please note you have a duty to notify social care of this arrangement)












### Please tell us about your smoking habits

Do you smoke?  Yes  No  
 If Yes, what do you primarily smoke:  
 Pipe  Cigarettes  Cigar  Other \_\_\_\_\_  
 How many do you smoke a day? \_\_\_\_\_  
 Would you like advice on quitting?  
 Yes  No

**Please tell us about your alcohol consumption**

Questions (please circle your answers)	Unit scoring system				
	0	1	2	3	4
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times Per 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 questions below.**

1 UNIT	1.5 UNITS	2 UNITS		3 UNITS	9 UNITS	30 UNITS
 Normal beer half pint (284ml) 4%	 Small glass of wine (125ml) 12.5%	 Strong beer half pint (284ml) 6.5%	 Medium glass of wine (175ml) 12.5%	 Strong beer Large bottle/can (440ml) 6.5%	 Bottle of wine (750ml) 12.5%	 Bottle of spirits (750ml) 40%
 Single spirit shot (25ml) 40%	 Alcopops bottle (275ml) 5.5%	 Normal beer Large bottle/can (440ml) 4.5%		 Large glass of wine (250ml) 12.5%		

Questions (please circle your answers)	0	1	2	3	4
How often in the last year have you found that you were not able to stop drinking once you have started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost 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/friend/doctor or health worker been concerned about your drinking or advised you to 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  
16-19 = harmful drinking                    20+ = possible dependence

**Would you like information or advice about alcohol consumption?** YES  NO

Do you exercise regularly?  Yes  No

If so – What exercise do you take?

How often?

\*In accordance with the Data Protection Act, the practice needs consent if you are happy for a 3<sup>rd</sup> party to collect prescriptions, test results and other medical information on your behalf. Please complete this section if you would like to register a 3<sup>rd</sup> party.

I give consent for \_\_\_\_\_ to collect prescriptions on my behalf (Please note that we are unable to hand out prescriptions to anyone under the age of 15)

I give consent for \_\_\_\_\_ to obtain test results / medical information / appointment information on my behalf (Delete as appropriate)

IT IS YOUR RESPONSIBILITY TO ADVISE US OF ANY CHANGES TO THESE INSTRUCTIONS:

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

**Please record any additional information about you that you think is important for us to know**

#### **Electronic Prescription Service (EPS)**

EPS enables prescribers - such as GPs and practice nurses - to send prescriptions electronically to a dispenser (such as 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.

#### **Patient Participation / Reference Group (PPG) (PRG) or Virtual Group.**

The practice has an active patient participation group (PPG). This consists of a group of patients and practice staff. Come along and join us:

- Learn how your surgery ticks
- Learn what your surgery can do for you
- Exchange views and information
- Support your surgery
- Share your ideas from the patient perspective

We meet every 3 months, see the notice board in reception or our website for the next date and time.

We have found over the years that there are patients who would like to have a say on the development of the practice however for various reasons are unable to physically attend. We have therefore put together a 'Virtual' PPG where comments and suggestions can be made via e-mail on our Patient Comments section of our website [www.hazemeremc.co.uk](http://www.hazemeremc.co.uk). This means more patients can be 'virtual' members of the group.

**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     Any part of my body

For more information, please visit the website [www.uktransplant.org.uk](http://www.uktransplant.org.uk) or call 0300 123 23 23

**\*Signed**

**\*Date**        /        /        /

**Signed on behalf of patient** (*if applicable*)  
(e.g. for minors under 16 years old, adults lacking capacity)

**Once you are registered...**

If there are any problems with your registration we'll contact you to clarify any issues, but once your details have been entered into our computerized records...

On-line Services

...You will be able to register with our on-line service and access appointments, prescriptions and some sections of your own medical record via the internet. All of the details that you need for this are available by requesting to be registered at reception.

New Patient Health-check

...You will be eligible for a new patient health-check with a Practice Nurse/Health Care Assistant. Contact reception if you should like to take this up.

**FOR OFFICE USE ONLY**

**PHOTO ID**            **TYPE:** \_\_\_\_\_  
(Over 18 only)

**ADDRESS ID**            **TYPE:** \_\_\_\_\_