RICHMOND MEDICAL CENTRE

NEW PATIENT HEALTH CHECK

PLEASE COMPLETE PRIOR TO YOUR APPOINTMENT

Preferred Title:	**Town of birth:**
Surname:	**Country of birth:**
Forenames:	**Nationality**
Martial Status:	**Date of birth:**
Occupation:	**Age:**

	Current	Previous
House name / number:		
Street:		
Town:		
Postcode:		

Telephone home:	**Mobile number:**
Telephone work:	**Can we text you on your mobile ? YES /NO**
	If yes please complete attached form
Mobile number:	**Can we email you ? YES /NO**
Email:	**If yes please complete attached form**

Do you have any allergies: Yes / No (Please delete appropriately
If you answered yes to the above question please list your allergies below

Dietary Requirements
Please state any dietary requirements you have?

Have you ever been a regular smoker? Yes/No (Please delete appropriately
Do you currently smoke tobacco? Yes/No (Please delete appropriately

What type of tobacco do you smoke and how many per day?

	Type:	**Quantity**
▶	**Cigarettes**	
▶	**Pipe**	
▶	**Cigar**	
▶	**Roll Ups**	
▶	**Recreational Drugs**	

If you need help to stop smoking ask.

How much alcohol do you consume in a week?

- ▶ **Wine:** _____ **Units per week (1.5 per glass)**
- ▶ **Beer:** _____ **Units per week (2 per pint)**
- ▶ **Spirits:** _____ **Units per week (1 per measure)**

BMA advice suggests an upper limit of 14 units/wk for women and 21 for men

Family History Parents - Brothers - Sisters - Children

Have any of the following illnesses run in your immediate family:

▶ **Heart Disease**	**Yes/No**	**Who**	**Age at diagnosis**
▶ **High Blood Pressure**	**Yes/No**	**Who**	**Age at diagnosis**
▶ **Stroke**	**Yes/No**	**Who**	**Age at diagnosis**
▶ **Diabetes**	**Yes/No**	**Who**	**Age at diagnosis**
▶ **Asthma**	**Yes/No**	**Who**	**Age at diagnosis**
▶ **Epilepsy**	**Yes/No**	**Who**	**Age at diagnosis**
▶ **Cancer**	**Yes/No**	**Who**	**Age at diagnosis**
▶ **Any other not mentioned**	**Yes/No**	**Who**	**Age at diagnosis**

Exercise
Please indicate the type of exercise you participate in?

Type of exercise?	**Answer**	**How often over a 4 week period of 20mins or more**			
		1-4 times	**5-11 times**	**12+times**	
Enjoy light exercise	**Yes/No**				
Enjoy moderate exercise	**Yes/No**				
Enjoy Heavy exercise	**Yes/No**				
Competitive athlete	**Yes/No**				
Aerobic exercise	**Yes/No**				
Attend exercise classes	**Yes/No**				
Do not do any exercise	**Yes/No**				

Past Medical History
Have you ever had any of the following. If YES please give details

- **High Blood Pressure**
- **Thyroid Disorder**
- **Diabetes (If Yes please specify Diet, Tablets or Insulin controlled)**
- **Lung Disease(Including Asthma, Chronic Bronchitis, Clot on Lung**
- **Skin Disease(Including Eczema,Psoriasis, Acne**
- **Epilepsy**
- **Migraine**
- **Cancer (If Yes please state where**
- **Hysterectomy**
- **Infertility**
- **Vasectomy**
- **Parkinson's Disease**
- **High Cholesterol/Lipids**
- **Arthritis (If Yes specify whether Rheumatoid or Osteo**
- **Hay Fever**
- **Heart Disease (including Angina, Heart attack, Valve problems,**
- **Heart Failure)**
- **Stroke**

Any other illness not mentioned?

Please List any current medication

Decription	Strength	Quantity

Have you had any side effects to any medications YES/NO
If Yes, give details

FEMALES

How many pregnancies have you had?

How many children do you have?

Sex	Age		Sex	Age

When was your last smear test?

What was the result?

Are you Pregnant?

Are you Disabled? YES/NO

CARER

Do you look after someone **YES/NO**
Does someone look after you **YES/NO**

Who do you care for ? (e.g. Parent, Son, Daughter, Husband)

During the last month have you often been bothered about feeling down, depressed or hopeless?

During the last month have you often been bothered by having little interest or pleasure in doing things?

TO BE COMPLETED AT RICHMOND MEDICAL CENTRE

Height **Weight**

Blood Pressure **MSU** **Blood** **Protein** **Glucose**

Tetanus/Polio up to date **Results**

DNA explained

PATIENT ETHNIC ORIGIN QUESTIONNAIRE

This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act.

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

Choose ONE section from A to E, and then tick ONE box to indicate your background.

Name ..... Date of Birth .....

A White

	British
	Irish
	Any other white background please write in below

B Mixed

	White and Black Caribbean
	White and Black African
	White and Asian
	Any other mixed background please write in below

C Asian or Asian British

	Indian
	Pakistani
	Bangladeshi
	Any other Asian background please write in below

D Black or Black British

	Caribbean
	African
	White and Asian
	Any other Black background please write in below

E Chinese or other ethnic group

	Chinese
	Any other please write below

Main spoken language English ☐

 Main spoken language : .....

The Alcohol Use Disorders Identification Test: Self-Report Version

Because alcohol can affect your health and can interfere with certain medications and treatments, it is important that we ask you some questions about your use of alcohol. Your answers will remain confidential so please be honest. Please give yourself a score in the right hand column. In order to work out your units of alcohol there is an attached sheet which you can use and take away for future reference. Please hand this to the medical assistant, nurse or doctor who can interpret it for you.

Questions	0	1	2	3	4	Your answer 0-4
1 How often have you had a drink containing alcohol?	never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2 How many units of alcohol do you have on a typical day, when you are drinking?	1 to 2.5	2.6 to 5	5.1 to 7.5	7.6 to 11	Over 11	
3 How often do you have six or more units on one occasion	never	Less than monthly	monthly	weekly	Daily or almost daily	
4 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	
5 How often during the last Year have you failed to do what was normally expected of you because of drinking?	never	Less than monthly	monthly	weekly	Daily or almost daily	
6 How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	never	Less than monthly	monthly	weekly	Daily or almost daily	
7 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	
8 How often during the last year have you been unable to remember what happened the night before because of your drinking?	never	Less than monthly	monthly	weekly	Daily or almost daily	
9 Have you or someone else been injured because of your drinking?	no		Yes, but not in the last year		Yes, during the last year	
10 Has a relative, friend, doctor or other health professional been concerned about your drinking or suggested you cut down?	no		Yes, but not in the last year		Yes, during the last year	
					TOTAL	

Richmond Medical Centre thanks you for the time you have spent with us calculating this score and hopes it has proved helpful for you.

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The way you work out your units of alcohol is as follows:

Standard Lager (4%) 1pint (568ml)	2.3
Standard beer (bitter and mild) 3.5% 1 pint (568ml)	2
A premium beer or lager 330ml bottle (5%vol)	1.7
A pint (568ml) of premium beer or lager (5%vol)	2.8
Super strength lager 440ml can (9%)	4
Whisky 35ml measure (40%)	1.4
Whisky 25ml –a single	1
Gin vodka rum 35ml (37.5%)	1.3
Gin vodka rum 25ml a single	1
750 ml bottle champagne or wine (12%)	9
175ml glass wine or champagne(12%) (some larger glasses for wine are more)	2.1 3
125ml glass wine or champagne (12%)	1.5
Regular cider (5%) 1pint (568ml)	2.8
Strong cider (8.5%) 275 ml bottle	2.3
Vermouth (15%) 50ml glass	0.8
Port (20%) 50ml glass	1
Sherry (17.5%) 50ml glass	0.9
Alcopop (5%)275ml bottle ready to drink	1.4

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Patient Consent for

Text Message Reminders & E-mails

Richmond Medical Centre would like to make increasing use of new technologies to communicate with patients. We currently have text messaging to remind patients of their forthcoming appointment. We would also like to make increasing use of e-mails to keep patients informed of practice developments.

Text and Voice Messaging

As well as reminding patients of their appointments, will be able to inform them of changes in practice services or opening hours, invite them to attend for flu vaccinations or medication and annual reviews.

E-Mails

The surgery requires consent to contact patients by email for the purposes of health promotion and for sending out newsletters. Our Patient Participation Group (PPG) produces newsletters during the year to inform and educate patients on any changes within the practice and health matters. In order to reach more patients, and to save on printing costs, we would like to distribute the newsletter via e-mail. Emails are generated using a secure facility however they are transmitted over a public network and as such may not be secure, however the practice will not transmit any information which would enable an individual patient to be identified.

If you are happy to consent to any, or all of the above, please complete the form below and hand it to the receptionist.

Full Name		**CONSENT GIVEN** **(Please tick relevant boxes)**
Date of Birth		
Mobile Number		YES ☐ NO ☐
Home Telephone Number		YES ☐ NO ☐
e-mail address		YES ☐ NO ☐
Signature		

Disclaimer

If you agree to the practice contacting you via your mobile phone or fixed land line number, we agree to adhere to the following:

1. The mobile phone number or fixed land line number will only be used by the practice in relation to the healthcare services offered by the practice. You will not be contacted in relation to any other types of products or service .and your information will not be passed to any other parties.
2. If at any time you would like to opt out of either of the above services, please make a personal request to the practice and you will be opted out of the service within 48 hours. You may also like to include your reason for opting out, to help us review and improve the service in future.

E-mails will only be sent by the practice staff and e-mail addresses will not be passed on to any other parties.

A new way to get your medicines and appliances

The Electronic Prescription Service (EPS) is an NHS service. It gives you the chance to change how your GP sends your prescription to the place you choose to get your medicines or appliances from.

What does this mean for you?

If you collect your repeat prescriptions from your GP you will not have to visit your GP practice to pick up your paper prescription. Instead, your GP will send it electronically to the place you choose, saving you time.

You will have more choice about where to get your medicines from because they can be collected from a pharmacy near to where you live, work or shop.

You may not have to wait as long at the pharmacy as there will be time for your repeat prescriptions to be ready before you arrive.

Is this service right for you?

Yes, if you have a stable condition and you:

- don't want to go to your GP practice every time to collect your repeat prescription.
- collect your medicines from the same place most of the time or use a prescription collection service now.

It may not be if you:

- don't get prescriptions very often.
- pick up your medicines from different places.

How can you use EPS?

You need to choose a place for your GP practice to electronically send your prescription to. This is called nomination. You can choose:

- a pharmacy.
- a dispensing appliance contractor (if you use one).
- your dispensing GP practice (if you are eligible).

Ask any pharmacy or dispensing appliance contractor that offers EPS or your GP practice to add your nomination for you. You don't need a computer to do this.

Can I change my nomination or cancel it and get a paper prescription?

Yes you can. If you don't want your prescription to be sent electronically tell your GP. If you want to change or cancel your nomination speak to any pharmacist or dispensing appliance contractor that offers EPS, or your GP practice. Tell them before your next prescription is due or your prescription may be sent to the wrong place.

Is EPS reliable, secure and confidential?

Yes. Your electronic prescription will be seen by the same people in GP practices, pharmacies and NHS prescription payment and fraud agencies that see your paper prescription now.

Sometimes dispensers may see that you have nominated another dispenser. For example, if you forget who you have nominated and ask them to check or, if you have nominated more than one dispenser. Dispensers will also see all the items on your reorder slip if you are on repeat prescriptions.

If you are unhappy with your experience of nomination

You can complain to the pharmacy, dispensing appliance contractor (DAC) or GP practice. You can also complain to NHS England or their local NHS Clinical Commissioning Group (CCG) if your complaint cannot be resolved www.england.nhs.uk/contact-us/complaint/

For more information visit
www.hscic.gov.uk/epspatients, your pharmacy or GP practice. (Dec 2014)

NHS

Your Electronic Patient Record & the Sharing of Information

- A Patient's Guide

Please read this leaflet carefully. It will give you information about the sharing of your electronic patient record and the choices you need to make

Today, electronic records are kept in all the places where you receive healthcare. These NHS Care Services can usually only share information from your records by letter email, fax or phone. At times, this can slow down your treatment and mean information is hard to access.

Your GP practice uses a computer system called SystmOne that allows the sharing of full electronic records across different NHS Care Services. We are telling you about this as a patient at this practice as you have a choice to make about how your practice shares information about your care from your electronic patient record. This form is not about your Summary Care Record (SCR), it is asking your sharing preferences regarding your full electronic GP record. You can choose to share or not to share your electronic GP record with other NHS Care Services.

How is my decision recorded?

Your GPs computer system has two settings to allow you to control how your medical information is shared:

Sharing Out – This controls whether your full GP electronic patient record can be shared with other NHS Care Services where you are treated. Please record your preference:

Please tick: Sharing Out **Yes** (shared) ☐ or **No** (not shared) ☐

Sharing In – This controls whether you agree for this practice to view information you've agreed to share at other NHS Care Services. Please record your preference:

Please tick: Sharing In **Yes** (viewable) ☐ or **No** (not viewable) ☐

Patient Name (Print Name): _____

Date of Birth: ____/____/____

Patient Signature: _____ Date: ____/____/____

NHS Family doctor services registration

GMS1

Patient's details

Please complete in BLOCK CAPITALS and tick ☑ as appropriate

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname

Date of birth

First names

NHS No.

Previous surname/s

☐ Male ☐ Female

Town and country of birth

Home address

Postcode

Telephone number

Please help us trace your previous medical records by providing the following information

Your previous address in UK

Name of previous doctor while at that address

Address of previous doctor

If you are from abroad

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

If you are returning from the Armed Forces

Address before enlisting

Service or Personnel number

Enlistment date

If you are registering a child under 5

☐ I wish the child above to be registered with the doctor named overleaf for Child Health Surveillance

If you need your doctor to dispense medicines and appliances*

**Not all doctors are authorised to dispense medicines*

☐ I live more than 1 mile in a straight line from the nearest chemist

☐ I would have serious difficulty in getting them from a chemist

☐ Signature of Patient ☐ Signature on behalf of patient Date_____/_____/_____

Version 01/02

Please see overleaf re: Organ donation

Family doctor services registration

GMS1

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

Signature confirming my agreement to organ/tissue donation Date ____/____/____

For more information, please ask at reception for an information leaflet or visit the website www.uktransplant.org.uk, or call 0300 123 23 23.

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.

Tick here if you have given blood in the last 3 years ☐

Signature confirming consent to inclusion on the NHS Blood Donor Register Date ____/____/____

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:

To be completed by the doctor

Doctors Name HA Code

☐ I have accepted this patient for general medical services

☐ For the provision of contraceptive services

☐ I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice

Doctors Name, *if different from above* HA Code

☐ I am on the HA CHS list and will provide Child Health Surveillance to this patient **or**

☐ I have accepted this patient on behalf of the doctor named below, who is a member of this practice and is on the HA CHS list and will provide Child Health Surveillance to this patient.

Doctors Name, *if different from above* HA Code

☐ I will dispense medicines/appliances to this patient subject to Health Authority's Approval

☐ I am claiming rural practice payment for this patient.
Distance in miles between my patient's home address and my main surgery is

I declare to the best of my belief this information is correct and I claim the appropriate payment as set out in the Statement of Fees and Allowances. An audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission.

Authorised Signature

Name Date ____/____/____

Practice Stamp

HA use only Patient registered for ☐ GMS ☐ CHS ☐ Dispensing ☐ Rural Practice