

## New Patient Questionnaire

### WELCOME TO OUR PRACTICE - Patients Under 14

First Name		Last Name	
Any previous First Names		Any previous Last Names	
Current Address		Date of Birth	
Post code		Place of Birth	
Previous Address & Post Code		Tel: Home	
		Tel: Mobile (parent/carer)	
Main spoken language		Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Mother's Full Name		Mother's Date of Birth	
Mother's Address (If different to patient's)		Father's Full Name	
Father's Address (If different to patient's)		Father's Date of Birth	
Name of Person(s) with parental responsibility		Name of Primary Carer(s)	
Name & Address of Previous Doctor		Name of Previous Health Visitor	
Name and Address of Current School		Name and Address of Previous School	
Ethnic origin	White British/Other white background/ White & Asian/Indian/Pakistani/ Other mixed/Other Asian background/ Caribbean/African/Chinese/ Other black background/Other/Refuse to disclose		
Have you received information on the Summary Care Record? (SCR is where your basic medical history is shared with hospitals across England in case of an Emergency)			<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wish to opt out? (i.e. <u>not let any</u> information about you be available to hospitals, A&E or Out of Hours, if needed)			<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><b>Do you consent to us contacting you by text and/or e-mail about your child?</b></p> <p><input type="checkbox"/> Yes by text and e-mail      <input type="checkbox"/> Yes by text only      <input type="checkbox"/> Yes by e-mail only      <input type="checkbox"/> No</p> <p>Under the Data Protection Act we have to inform you that the contents of any e-mails will not be confidential and secure. Any information we obtain from you will be used only for us to communicate with you. This information will not be passed on to any third party and will not be kept for longer than necessary. Confidentiality and security cannot be guaranteed whilst in transit and all e-mails should contain the minimum of identifiable information. Any e-mails you send will be stored on your e-mail provider's server and should be deleted as soon as possible as the NHS have no control over these mail servers.</p> <p><b>PLEASE NOTE: YOU CAN VIEW OUR PRIVACY NOTICE ON OUR WEBSITE: <a href="http://www.wyreforesthealthpartnership.co.uk">www.wyreforesthealthpartnership.co.uk</a>.</b></p>			
Do you take any regular medications? <input type="checkbox"/> Yes <input type="checkbox"/> No (If YES, please attach copy of your repeat prescription request form )			

**Note:** If you have nominated a specific pharmacy for your prescriptions you may need to change this to a more local pharmacy.

**Do you have any allergies to any drugs, food or other substances?**  Yes  No (If YES, please give details)

I need to carry an adrenaline pen

**Have you, your parents, siblings suffered with any of the following (if YES who and at what age)?**

Asthma/COPD		Heart Attack/Heart Disease	
Mini Stroke/Stroke/TIA		Epilepsy	
High Blood Pressure		Diabetes	
Glaucoma		Cancer	
Kidney Disease		Depression/Mental Health problems	
Learning Difficulties		Thyroid problems	
Osteoporosis		Atrial Fibrillation	
Dementia		Other	

**Are you currently under Hospital Care?**

Hospital Name

Consultant

Nature of Problem

**Are you childhood Immunisations Up-to-Date? DTP, Polio, Meningitis, Hib, Pneumococcal, MMR, Rotavirus**

Yes  No

**New patients or temporary registrations will not be accepted without proof of identification and proof of address. To register a child under-14 the parent/care will need to show the birth-certificate to complete the registration process.**

**This information will only be used by doctors and staff of the Medical Centre and will be treated with confidentiality.**

**Parent/Carer needs to sign and date the form.**

**Name** \_\_\_\_\_ **Date** \_\_\_\_\_

*For office use only*

Two forms of identity seen? 1]  
2]

Checked by:  
Please inform the patient of their named GP and record it here