

Patient's details

Please complete in **BLOCK CAPITALS** and tick as appropriate

<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms	Surname
Date of birth	First names
NHS No.	Previous surname/s
<input type="checkbox"/> Male <input type="checkbox"/> 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
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If you are returning from the Armed Forces

Address before enlisting

Service or Personnel number	Enlistment date
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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

NHS Organ Donor registration

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death. Please tick as appropriate

- Kidneys
 Heart
 Liver
 Corneas
 Lungs
 Pancreas
 Any part of my body

Signature confirming consent to organ donation

Date

For more information, please ask for the leaflet on joining the NHS Organ Donor Register

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 CHSlist 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

BRANNAM MEDICAL CENTRE - NEW PATIENT QUESTIONNAIRE

These questions are designed to help us offer you the best possible health care. The information you give will, of course, be treated confidentially.

NAME **TEL.NO**

What is your **OCCUPATION?**

Are you Unemployed? YES/NO Retired? YES/NO

If you are under 16 years Name of School

Main Carer

Are you a Carer? YES/NO Do you wish to be included on the Carer's List? YES/NO

Please indicate your nationality/ethnicity:

Please indicate your first language:

NEXT OF KIN/EMERGENCY CONTACT

Name: Relationship:.....

Address: Tel. No:.....

..... Key holder:

Do you live alone? YES/NO

Do you have a Carer YES/NO Name of Carer

Are you **ALLERGIC** to any drugs / substances?

Please give details.....

MEDICAL HISTORY – PAST AND PRESENT

Please list any serious illnesses, operations, accidents or chronic disabilities:

.....
.....

At the present time, are you under the care of any hospital? YES/NO

Please give details:

.....

FAMILY HISTORY - Have any of your relatives had:

Heart disease YES/NO Stroke YES/NO

High Blood Pressure YES/NO Diabetes YES/NO

Asthma YES/NO

Have any of your relatives had a heart attack or stroke before the age of 60? YES/NO

If YES, please give details:

.....

Please Turn Page Over

MEDICATION - Are you taking any prescribed medication?:

Please list:

Do you take regular over the counter medication, e.g. aspirin? YES/NO

Please list:

HEALTH SCREENING

Weight:..... Height:

Do you **SMOKE**? Never Smoked
 Ex-Smoker Stopped in

 Current Smoker Cigarettes per week

Would you like help to stop smoking? **If yes, please ask the receptionist for details.**

ALCOHOL

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink that contains alcohol?	Never	Monthly or less	2-4 times per month	4+ times per month	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	7-8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring: a total of 5+ indicates hazardous or harmful drinking
(EMIS code 9k17)

Do you consider your **Diet** to be: Poor Average Good

What sort of **EXERCISE** do you take each week?

 Physically Impossible None Light

 Moderate Heavy Competitive Athlete

Have you had your **BLOOD PRESSURE** checked within the last 5 years? YES/NO

If no, please ask for an appointment with the nurse for a BP check

Have you definitely had any of the following **VACCINATIONS**? Please give year.

Tetanus Polio Influenza.....

Rubella Hepatitis B Pneumonia

YOUR MEDICAL RECORD – PATIENT CONSENT

The NHS is moving towards Electronic Patient Records (ECR's), stored centrally and accessible to a wide variety of NHS staff – although with the strictest safeguards to protect medical information and preserve confidentiality.

At first these will consist only of basic 'demographic' information (like names, addresses, NHS number etc) as well as some information extracted from your GP record about e.g. allergies, adverse reactions and the medication you take.

Gradually, however, the records will grow to include as much information as possible about the treatment you receive both from your own family doctor, hospital consultants and attached staff like physiotherapists or specialist nurses. They could improve communication and make emergency treatment quicker and better. But anonymised versions will also be accessible by non-clinical NHS staff for audit, research, public health surveillance etc.

Do you consent for Brannam Medical Centre to share your medical record with other organisations providing care for you?

Yes I consent Signed Date

No I do not consent Signed Date

FEMALE PATIENTS

Have you had a cervical smear within the past 5 years? YES/NO

Number of pregnancies

Year of birth of children

Thank you for completing this form
As a new patient, you are invited to have a New Patient Check
Please ask for an appointment

For administrative staff only

Staff Name:

Patient's Name :-

Patient consent scanned onto medical record?

New patient questionnaire completed 9187	YES/NO	
New patient screen verbal invite 90W7	YES/NO	
New patient screen refused 90W2	YES/NO	
New patient consultation booked with GP	YES/NO	Appt Date:-
New patient screen requested with nurse 68R1	YES/NO	Appt Date:-
New patient screen done 68R2	YES/NO	
DNA new patient screen 90W7	YES/NO	

Please sign and return to reception manager following registration for audit purposes