|  |  |  |  |
| --- | --- | --- | --- |
| **Title:** | **First name:** | **Surname:** | **DOB:** |
| **Home number:**  | **Mobile number:** |
| **Please select prefer method of contact Home Mobile I consent to receiving SMS text messages from the practice** |
| **Do you have a carer?** **Yes No**  | **Carer’s Details****Name:****Contact Number:** | **Are you a carer?****Yes No** | **Patient you care for****Name:****DOB:**  |
| **Next of kin details****Name:** **Contact Number: Relationship:** |
| **Please Nominate a pharmacy that you would like your prescriptions sending to. This can be changed at any time.**Pharmacy name **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **If you live more than 1 mile away from a pharmacy, we will automatically add you to our list so you can collect your medication from our dispensary at the surgery.** |
| **Repeat medications** **Are you currently taking any medications regularly on a repeat prescription?** Yes No*If yes, please provide a list of your current medications to that they can be added to your records.***Your medications may need to be reviewed before they can be issued by your new GP. Please allow enough time for this. Once you are fully registered, repeat medication requests are processed within 48 hours. Acute (one off) requests are processed within 5 working days.**  |
| **Summary Care Record (SCR’s are created for all new patients unless you opt. out) Please tick one option.** Express consent for medications, allergies and adverse reactions only Express consent for medication, allergies, adverse reactions and additional information Express dissent – patient does not want a summary care record*The SCR is an electronic record of important patient information, created from GP medical records. It can be seen and used by authorised staff in other areas of the health and care system involved in the patient's direct care e.g. A&E / 111***Record Sharing (with other organisations e.g. District Nurses, Community Podiatry, Dieticians, Diabetes Services etc.)**Does the patient consent to the **sharing of data** recorded here with any other organisation that may care for the patient?  Yes NoDoes the patient consent to the **viewing of data** by this organisation that is recorded at other care services that may care for the patient? Yes No |
| **Your named accountable GP is Dr Archer.** Your GP is responsible for your overall care at the practice. If you have a different preference please let us know. The practice will make reasonable efforts to accommodate your request. |

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| New Patient Screening Questionnaire |
| **Ethnic Origin (Please tick)**  |
| **White British or mixed British** |  | **Indian or British Indian** |  | **Caribbean**  |  |
| **White Irish** |  | **Pakistani or British Pakistani** |  | **African** |  |
| **Other White background** |  | **Bangladeshi or British Bangladeshi** |  | **Other, Please state** |  |
| **White & Black Caribbean** |  | **Chinese** |  |  |  |
| **White & Black African**  |  | **Other Asian Background** |  | **Prefer not to say** |  |
| **White &Asian** |  |  |
| **Other Mixed Background** |  |

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| --- | --- |
| **Main Language spoken:**  | **Do you require an Interpreter?**  |

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| --- |
| **Past Medical History/ family History**Please tick if you or any of your immediate blood relatives have any of the following conditions |
|  | **Myself** | **Family History** |  | **Myself** | **Family History**  |
| Epilepsy |  |  | Rheumatoid Arthritis |  |  |
| High Blood Pressure |  |  | Mental illness |  |  |
| Heart Attack |  |  | Diabetes (Type 1 or 2) |  |  |
| Angina |  |  | Asthma |  |  |
| Stroke/ TIA |  |  | COPD |  |  |
| Osteoporosis |  |  | Cancer |  |  |
| **Any other relevant medical history:**  |
| **Do you have any allergies?:**  |

|  |
| --- |
| **Smoking Status (please tick)Non Smoker Ex-Smoker Current Smoker** *For advice on quitting you can self-refer to LiveWell Derby by calling 01332 641254*  |
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| **Alcohol Intake (Please circle the responses that fit best)** | **0** | **1** | **2** | **3** | **4** |
| 1. How often do you have 8 (men) / 6 (women) or more drinks on one occasion?
 | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| 1. 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 |
| 1. 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 |
| 1. Has a relative / friend / doctor / health worker been concerned about your drinking or advised you to cut down?
 | No | \_ | Yes - not in the last year | \_ | Yes – during the last year |

**Patient Participation group (PPG)**The purpose of the PPG is to review feedback from service users. We meet a few times a year to ensure that patients and carers are involved in decisions about the range, shape and quality of services provided by our practice. Would you like to join our PPG? Yes No |
| **Signature of patient/ patient representative Today’s date** |
| **If signed on patients behalf, please print your name:** |
| **Relationship to patient:**  |