Your named GP is:

Thank you for applying to join Latham House Medical Practice. 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 competed 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 | \* First Name |
| \* Any previous surname(s) | \* Date of birth |
| [ ]  Male [ ]  Female [ ]  Intermediate [ ]  Unspecified  | \* NHS number  |
| Town and country of birth | \* Home address & Postcode |
| Home telephone No. Preferred number [ ] Yes [ ] No | \* Previous address & Postcode |
| Work telephone No. Preferred number [ ] Yes [ ] No |  |
| Mobile telephone No. Preferred number [ ] Yes [ ] No | Email address |

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| --- | --- |
| \* Previous GP details  | 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: |
| (for women only) Have you had a cervical smear?[ ]  Yes [ ]  No *(Please state where, when and the results if possible)* | Marital Status? [ ]  Single [ ]  Married [ ]  Divorced [ ]  Widowed  |

**Additional details about you**

|  |  |
| --- | --- |
| What is your ethnic group? | Main language spoken?*(E.g. English)* |
| White [ ]  British [ ]  Irish  |
| Black [ ]  Caribbean [ ]  African |
| Asian [ ]  Indian [ ]  Pakistani [ ]  Chinese |
| Mixed [ ]  White + Black Caribbean [ ]  White + African [ ]  White + Asian |
| Other [ ]  *Please specify:* |

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| --- |
| Have you ever been in the employ of the Armed Forces? [ ]  Yes [ ]  NoPersonnel Number: Date Enlisted: Date Left: Are you a dependent of a current serving member of British Armed Forces? [ ]  Yes [ ]  No |

Next of kin \ Emergency contact

|  |  |
| --- | --- |
| Name of next of kin \ Emergency contact | Relationship to you |
| Next of kin \ Emergency contact telephone number(s) | Next of kin \ Emergency contact address *(if different to above)* |

Data Sharing ESCR

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| Enhanced summary care records allow out of hours and emergency care providers to obtain additional information than the basic summary care record from the NHS spine (central computer system) about patients, with their consent. Summary care records were initially created with an opt out clause in terms of consent (so most people have them. They allow out of hours and urgent care to access information about: medication, allergies and adverse reactions. They are used to assist health professionals with emergency and out of hours care.Enhanced summary care records will allow further information including: significant past medical history and procedures, immunisations, end of life care information, anticipatory care information and communication preferences to be obtained. This is an opt in process so patient have to agree for their record to be enhanced.Enabling access to an enhanced summary care record is the patient’s choice but may make it easier for out of hour’s providers to treat them in an emergency. I CONSENT TO MY ENHANCED SUMMARY CARE RECORD BEING SHARED [ ]  Yes [ ]  No |

|  |
| --- |
| \* Do you consent to receive the following type of communication (if offered) from Latham House Medical Practice? Email [ ]  Yes [ ]  NoMobile phone text messages [ ]  Yes [ ]  NoAnswering machine messages [ ]  Yes [ ]  No |

**Carers Information**

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 Cares Allowance, but not a wage and the care they are giving will significantly affect their own life.

|  |
| --- |
| Are you looked after by someone whose support you could not manage without? [ ]  Yes [ ]  NoIf yes, what is their name and contact number? Do you consent for your carer to be informed about you medical care? [ ]  Yes [ ]  No |

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| Do you look after or support someone who couldn’t manage without you? [ ]  Yes [ ]  NoIf yes, do you look after someone who is a patient at Latham House? [ ]  Yes [ ]  No [ ]  Don’t knowIf 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 medication? [ ]  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?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Epilepsy  | [ ]  Yes | Year: | Mental illness | [ ]  Yes | Year: |
| High Blood Pressure  | [ ]  Yes | Year: | Diabetes | [ ]  Yes | Year: |
| Heart Attack / Angina | [ ]  Yes | Year: | Asthma | [ ]  Yes | Year: |
| Stroke / Mini-stroke (TIA) | [ ]  Yes | Year: | COPD (or Emphysema) | [ ]  Yes | Year: |
| Cancer | [ ]  Yes | Year: | Osteoporosis / Bone fractures | [ ]  Yes | Year: |
| Rheumatoid Arthritis  | [ ]  Yes | Year: | Peripheral vascular disease | [ ]  Yes | Year: |

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| Do you have any disabilities, illness 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.  |

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| **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 **http://www.england.nhs.uk/ourwork/accessibleinfo/**  |

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| High blood pressure | [ ]  Yes | Who: | DVT/ Pulmonary Embolism  | [ ]  Yes | Who: |
| Ischaemic Heart Disease*Diagnosed aged >60 years* | [ ]  Yes | Who: | Breast Cancer | [ ]  Yes | Who: |
| Ischaemic Heart Disease*Diagnosed aged <60 years* | [ ]  Yes | Who: | Any Cancer*Specific type:* | [ ]  Yes | Who: |
| Raised Cholesterol | [ ]  Yes | Who: | Thyroid Disease  | [ ]  Yes | Who: |
| Stroke / CVA | [ ]  Yes | Who: | Epilepsy | [ ]  Yes | Who: |
| Asthma | [ ]  Yes | Who: | Osteoporosis  | [ ]  Yes | Who: |

Please tell us about your smoking habits.

|  |  |
| --- | --- |
| Do you smoke? [ ]  Yes [ ]  NoIf yes, what do you primarily smoke [ ]  Cigarettes [ ]  Cigar [ ]  Pipe | Are you an ex-smoker? [ ]  Yes [ ]  NoWhen did you quit?How many did you used to smoke a day?  |
| How many do you smoke a day? Would you like advice on quitting?[ ]  Yes [ ]  No |  |

Please tell us about your alcohol consumption:

ALCOHOL

How many units of alcohol do you drink per week on average? ...................................................



|  |
| --- |
| Do you exercise regularly? [ ]  Yes [ ]  NoIf so – What exercise do you take?How often? |

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

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| **Electronic Prescription Service (EPS)**EPS enables prescribers – such as GPs and Practice Nurses – to send prescriptions electronically to a dispenser (such a pharmacy) of the patient’s choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff.  |
| Do you have a nominated Pharmacy? [ ]  Yes [ ]  No *If yes – please tell us which Pharmacy it is*Would you like to have a nominated Pharmacy? [ ]  Yes [ ]  No *If yes – tell us which Pharmacy you have chosen*  |

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| **For information about the Practices Patient Reference Group (PRG) visit their website www.lathamhouseprg.org.uk** |

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| 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 bodyFor more information, please visit the website www.uktransplant.org.uk or call 0300 123 2323  |

|  |  |
| --- | --- |
| \* Signed  | \* Date  |

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

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| --- |
| Visiting the UK information leaflet shared with Patient? [ ]  Yes [ ]  No |

**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

As a patient at Latham House you have the opportunity to register for online services know as Patient Access.

Patient access allows you to order repeat medications, book routine appointments and view certain aspects of your medical records online via the internet if aged 16 years. There is a separate registration process that must be completed prior to accessing our services online. You will need to provide a form of photo ID. Further information is available at

**I have photo ID with me today and I would like to sign up for patient access** **[ ]**

**I would like the request to view my medical records online** [ ]

* **Please note that this will only be possible once we have received your medical records (2-6 months)**

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 USEPhoto ID / Birth Certificate Proof of Address EHIC Visa / Residency Permit  [ ]  [ ]  [ ]  [ ]  Appointments Booked: Date ………………………………. Time ………………………………. With …………………………………….Date ………………………………. Time ………………………………. With …………………………………….Date ………………………………. Time ………………………………. With …………………………………….Notes …………………………………………………………………………………………………………………… |
| Height: cm Age 5 and above Weight: kg Age 5 and aboveBlood Pressure: / Age 16 and above  |