LADYGATE LANE SURGERY

|  |  |
| --- | --- |
| **ID requirement for parents/ADULTS:** | **Passport or drivers licence and proof of address** |
|  |  |  |  |  |
| **Date** |   |  |  |
| **Your Details** |  |  |  |  |
| Forename |   |
| Surname |   |
| Date of Birth |   |
| Marital status |   |
| Address |   |
| Postcode |   |
| Mobile number |   |
| Home telephone number |   |
| Work telephone number |   |
| Email address |   |
| Occupation |   |
| Ethnic origin  |   |
| Sex | Male/ Female/ Transgender |  |  |
|  |  |  |  |  |
| **Language and Accessibility** |  |  |  |
| First language |   |
| If your first language is not English do you need translator  | YES/NO |
| Do you have any special communication needs?When we write to you or contact you, do you need us to communicate in a particular way? | YES/NO |
| If your answer is YES the receptionist will ask you some other questions to enable us to communicate with you effectively |
|  |  |  |  |  |
| **Next of Kin's Details** |  |  |  |  |
| Forename |   |
| Surname |   |
| Address |   |
| Postcode |   |
| Mobile number |   |
| Home telephone number |   |
|  |   |  |  |  |
| **Carer** |  |  |  |  |
| Do you have anyone who looks after you or your daily needs as Carer?  | YES/NO  |
| If yes, name and contact details: |  |  |  |
| Forename |   |
| Surname |   |
| Mobile number |   |
| Home telephone number |   |
| Are they registered with our Practice? | YES/NO |
| **Do you care for anyone else?** | YES/NO |
| If YES the receptionist will give you information about Hillingdon Carers and the support they offer |
|  |  |  |  |  |
| **Medical Information Needed** |  |  |  |
| Weight (approx) |   |  |  |  |
| Height |   |  |  |  |
|  |  |  |  |  |
| **Smoking** |  |  |  |  |
| Non smoker? | YES/NO |  |  |  |
| Ex-smoker? | YES/NO |  |  |  |
| Smoker? | YES/NO |  |  |  |
| If yes, how many a day? |   |  |  |  |
|  |  |  |  |  |
| **Medical History** |  |  |  |  |
| Please give details of any significant medical conditions and the approximate year of diagnosis: |
|  |  |  |  |  |
| Condition |   | Year |   |
| Condition |   | Year |   |
| Condition |   | Year |   |
| Condition |   | Year |   |
| Condition |   | Year |   |
| Condition |   | Year |   |
| Continue on back of sheet if necessary |  |  |  |
|  |  |  |  |  |
| **Allergies** |  |  |  |  |
| Are you allergic to any medication, substances or foods?  | YES/NO |
| If yes, please give details:  |  |  |  |  |
|   |
|  |  |  |  |  |
| **Family History** |  |  |  |  |
| Is there any of the following in your family *(father, mother, brother, sister)* before the age of 65? |
| Heart Disease? | YES/NO  | Which family member? |   |
| Stroke? | YES/NO  | Which family member? |   |
| Cancer? | YES/NO  | Which family member? |   |
| If Cancer - what type of Cancer? |   |
| Asthma? | YES/NO  | Which family member? |   |
|  |  |  |  |  |
| **Female Patients** |  |  |  |  |
| Date of most recent cervical smear |   |
| Result of most recent smear |   |
| Under 50 years old |  |  |  |  |
| Are your aware of your rubella (German measles) status? If not, would you like to have it checked?  | YES/NO |

**Online Password for Repeat Prescriptions (Patient Access)**

|  |  |
| --- | --- |
| Would you like to be provided with on line log in information  | YES/NO |
| Please sign to consent. Log in information will be emailed. | Signature: |

**Email and SMS**

|  |  |
| --- | --- |
| Would you like to receive SMS notification for clinical services? | YES/NO Signature: |
| Would you like to receive emails notification for clinical services? | YES/NO Signature: |

**Alcohol questionnaire**

For the following questions, please tick the answer which best applies.

1 drink = ½ beer or 1 glass of wine or 1 single spirit

|  |  |  |
| --- | --- | --- |
| **ALCOHOL CONSUMPTION** | **Scoring system** | **Your score** |
| **0** | **1** | **2** | **3** | **4** |  |
| How often do you have a drink containing alcohol? | Never | Monthlyor less | 2 - 4 times per month | 2 - 3 times per week | 4+ times per week |  |
| How many units of alcohol do you drink on a typical day when you are drinking? | 1 -2 | 3 - 4 | 5 - 6 | 7 - 9 | 10+ |  |
| How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |

Total Score : ­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_/12

Summary Care Record

Summary Care Records (SCR) contain key information about medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had in the past. Giving healthcare staff access to this information can prevent mistakes being made when caring for you in an emergency or when the surgery is closed. Your SCR will include your name, address, date of birth and your unique NHS number to help identify you correctly.

Sharing information with Health & Social Care Information Centre I am happy for my patient confidential data to be extracted from my local records and transferred to the HSCIC (Health and Social Care Information Centre). Yes/No

(No consent code for practice use 9nu0)

If you do not want a record, you will need to fill in a Summary Care Record opt out form and hand it into the surgery. Please ask at reception for the SCR opt out form.