***Much Wenlock & Cressage Medical Practice***

**Patient Questionnaire**

To help us maintain accurate patient records we would be very grateful if you could spend a few minutes completing this short questionnaire.

In addition to patient smoking history, we would also like to record the height, weight and ethnicity of our patients, as this will help in identifying people at most risk of certain medical conditions and identifying the most suitable treatment.

Once you have completed this form please return it to Reception.

**NAME**:………………………………………………… **DATE OF BIRTH**:…....................

(full name in capital letters please)

**HOME TELEPHONE NUMBER: ……………………………………………………………**

**MOBILE NUMBER: ………………………………………………………………………….**

**EMAIL ADDRESS:……………………………………………………………………………**

We send out electronic alerts of health campaigns/appointment reminders/Practice Information. Please tick the box if you are happy to receive information as follows:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| TEXT |  | EMAIL |  | BOTH |  |

Do you have any difficulties communicating; eg profoundly deaf, blind or speech impairment following illness/surgery? **Yes / No** (please circle as appropriate)

…………………………………………………………………………………………………….

If **Yes,** how can we help make information from the Practice more accessible to you? Eg large print information/use email/other:……………………………………………………….

**SMOKING HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
| Please tick one of the following boxes: |  | Tick as applicable | Number smoked |
| Current smoker |  |  |
| Ex smoker |  |  |
| Never smoked |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **If you are currently a smoker are you**: | | **If you are an ex-smoker did you give up**: | |
| Ready to give up? |  | Less than 12 months ago? |  |
| Thinking about giving up? |  | More than 12 months ago? |  |
| Not interested in giving up? |  | The date you gave up (approximately): |  |

**HEIGHT & WEIGHT DETAILS**

Height Weight

What is your first/ spoken language:…………………………………………………….…..

**Name: ………………………………………………… Date of Birth:……………………**

**ETHNICITY:**

**Please tick as appropriate**

|  |  |
| --- | --- |
| British or Mixed British |  |
| Irish |  |
| Other White Background |  |
| White & Black Caribbean |  |
| White and Black African |  |
| White & Asian |  |
| Other Mixed Background |  |
| Indian or British Indian |  |
| Pakistani or British Pakistani |  |
| Bangladeshi or British Bangladeshi |  |
| Other Asian Background |  |
| Caribbean |  |
| African |  |
| Other Black Background |  |
| Chinese |  |
| Other |  |
| Ethnic Category Not stated |  |

Name………………………………………………… DOB: ………………………. **ALLERGIES – Medication & Food**

|  |  |
| --- | --- |
| ALLERGY | DATE |
|  |  |

Do you take any regular medication **Yes/No** (please circle as applicable)

If **YES,** please give details:

|  |  |  |
| --- | --- | --- |
| Name of Drug | Strength (eg 5 mg, 2 puffs) | How often (eg 2 x a day) |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**PAST HISTORY**

**Operations**

|  |  |
| --- | --- |
| Operation | Date |
|  |  |

Have you ever had any serious illness which required hospital admission or are continuing to have treatment for illness, eg eczema

Please also include details about serious accidents/fractures

|  |  |
| --- | --- |
| Illness/Accident | Date |
|  |  |

|  |  |
| --- | --- |
| **Female Patients only** |  |
| Do you currently have a coil or contraceptive implant fitted? **Yes/No** (please circle as appropriate) | If **Yes** please tick relevant option:  Mirena Coil  Copper Coil  Nexplanon  **Date Above Fitted:** |

**SPECIFIC NEEDS**

Please detail below any specific needs you have so the Practice can ensure they are identified, recorded, and appropriate action taken.

|  |  |
| --- | --- |
| Please state any sensory impairment you have (ie speech, hearing, sight) |  |
| Are you an Assistance Dog user? | **Yes/No** (please circle as appropriate) |
| Please state any physical disabilities you have |  |
| Please state any mental disabilities you have |  |
| Please state any requirements you have to be able to access the Practice premises |  |
| Please state any religious or cultural needs |  |
| Do you require the help of a translator/interpreter? | **Yes/No** (please circle as appropriate) |
| Please state any specific nutritional requirements you have |  |
| Please state any phobias you have |  |
| If you are a carer, please state the name and address of the person you care for |  |
| If you have a carer please state their name/address/phone number and sign here if you wish us to disclose information about your health to your carer. |  |
| Signed: Date: |

Do you have a “Living Will” (a statement explaining what medical treatment you would not want in the future)?

|  |
| --- |
| **Yes/No** (please circle as appropriate)  If **Yes** please bring a written copy to your New Patient Medical |

Have you nominated someone to speak on your behalf, (eg a person who has Power of Attorney)?

|  |
| --- |
| **Yes/No** (please circle as appropriate)  If **Yes** please bring a written copy to your New Patient Medical |

|  |  |  |  |
| --- | --- | --- | --- |
| For office use only | Staff to complete | Information entered by | Date |
| Page 1/2 | Admin to enter |  |  |
| Page 3/4 | For Data Team |  |  |

**Thank you for completing this form**



**Information for new patients: about your Summary Care Record**

**Dear Patient,**

If you are registered with a GP practice in England you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. You may need to be treated by health and care professionals that do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs.

Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

**You have a choice**

You have the choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care.

Your options are outlined below; please indicate your choice on the form overleaf.

**Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies and adverse reactions only.

**Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies and adverse reactions and further medical information that includes: Your significant illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.

**Express dissent for Summary Care Record (opt out).** Select this option, if you **DO NOT** want any information shared with other healthcare professionals involved in your care.

Please note that it is not compulsory for you to complete this consent form. If you choose not to complete this form, a Summary Care Record containing information about your medication, allergies and adverse reactions and additional further medical information will be created for you as described in point b) above.

The sharing of this additional information during the pandemic period will assist healthcare professionals involved in your direct care and has been directed via the Control of Patient Information (COPI) Covid-19 – Notice under Regulation 3(4) of the Health Service Control of Patient Information Regulations 2002.

If you choose to complete the consent form below, please return it to your GP practice.

You are free to change your decision at any time by informing your GP practice.

**Summary Care Record Patient Consent Form**

Having read the above information regarding your choices, please choose **one** of the options below and return the completed form to your GP Practice:

**Yes – I would like a Summary Care Record**

□ Express consent for medication, allergies and adverse reactions only.

**or**

□ Express consent for medication, allergies, adverse reactions and additional information.

**No – I would not like a Summary Care Record**

□ Express dissent for Summary Care Record (opt out).

Name of Patient: ………………………………………………..…...............................................................

Address: …………………………………………………………………………………………………………………………….

Postcode: ………………………………………… Date of Birth: ………..........................................

NHS Number (if known): …………………………..………………...........................................................

Signature: ………………………………………………………….. Date: ………………………………………………

If you are filling out this form on behalf of another person, please ensure that you fill out their details above; you sign the form above and provide your details below:

Name: …………..........................................................................................................................

**Please circle one:** Parent Legal Guardian Lasting power of attorney

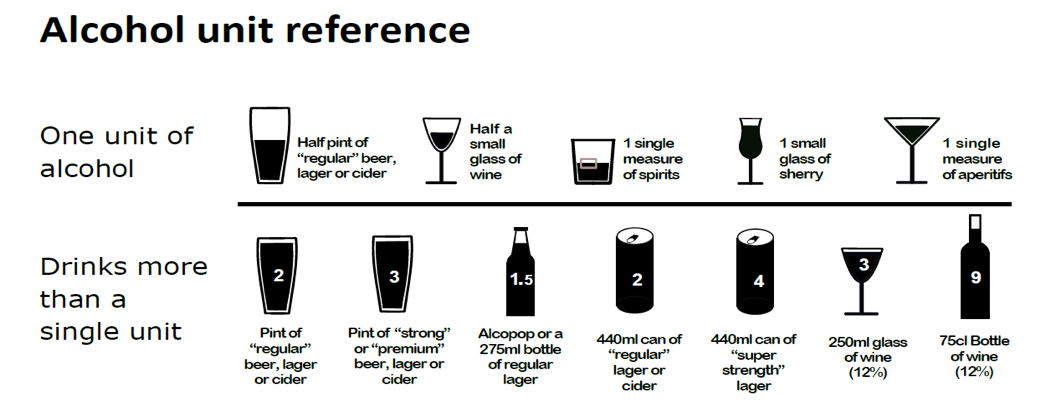
for health and welfare

If you require any more information, please visit <http://digital.nhs.uk/scr/patients> or phone NHS Digital on 0300 303 5678 or speak to your GP practice.

**For GP practice use only**

To update the patient’s consent status, use the SCR consent preference dialogue box and select the relevant option or add the appropriate read code from the options below:

|  |  |  |
| --- | --- | --- |
| **Summary Care Record Consent Preference** | **Read 2** | **CTV3** |
| The patient wants a core Summary Care Record (express consent for medication, allergies and adverse reactions only) | 9Ndm. | XaXbY |
| The patient wants a Summary Care Record with core and additional information (express consent for medication, allergies, adverse reactions and additional information) | 9Ndn. | XaXbZ |
| The patient does not want to have a Summary Care Record (express dissent for Summary Care Record – opt out) | 9Ndo. | XaXj6 |



|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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 | 2-3 times per week | 4+ times per week |  |
| How many alcoholic drinks do you have on a typical day when you are drinking? | 1-2 | 3-4 | 5-6 | 7-9 | 10+ |  |
| How often do you have 6 or more standard drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you found that you were not able to stop drinking once you had started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you failed to do what was normally expected from you because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you had a feeling of guilt or remorse after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you been unable to remember what happened the night before because you had been drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| Have you or somebody else been injured as a result of your drinking? | No |  | Yes, but not in the last year |  | Yes, during the last year |  |
| Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down? | No |  | Yes, but not in the last year |  | Yes, during the last year |  |

Please add up your scores from the above tables and write the total below:

**Total**…………………………..

**Scoring: 0 – 7 lower risk, 8 -15 increasing risk, 16 to 19 higher risk, 20+ possible dependence**

*If you would like help and advice on how to reduce your alcohol intake, please contact* [*https://www.drinkaware.co.uk/*](https://www.drinkaware.co.uk/) *or ask at reception*

# Application for Online Access to Services & Notifications

## PLEASE BRING 2 FORMS OF IDENTIFICATION TO PRACTICE WITH THIS FORM:

## 1 X ID WITH PHOTOGRAPH 1X CONFIRMATION OF ADDRESS

|  |  |
| --- | --- |
| **Surname** | **Date of birth** |
| **First name** | |
| **Address**    **Postcode** | |
| **Email address\*** | |
| **Telephone number** | **Mobile number\*** |

## I wish to have access to the following online services (please tick all that apply):

|  |  |
| --- | --- |
| 1. Booking appointments | 🞏 |
| 1. Requesting repeat prescriptions | 🞏 |
| 1. Accessing my medical record | 🞏 |

**I wish to access my medical record online and understand and agree with each statement (tick)**

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the practice | 🞏 |
| 1. I will be responsible for the security of the information that I see or download | 🞏 |
| 1. If I choose to share my information with anyone else, this is at my own risk | 🞏 |
| 1. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement | 🞏 |
| 1. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible | 🞏 |

**I wish to receive messages and alerts from the surgery such as notification of appointment reminders and blood test results via:**

**\*Email & mobile number required if you wish to receive notifications of appointments etc.**

|  |  |
| --- | --- |
| 1. SMS **Text** Message Alerts (please circle Yes or No) | Yes / No |
| 1. **Email** notifications (please circle Yes or No) | Yes / No |

|  |  |
| --- | --- |
| Signature | Date |

### For practice use only

|  |  |  |
| --- | --- | --- |
| Identity verified by (initials) | Date: | ID Vouching  Documents seen: |

# 

|  |
| --- |
| Much Wenlock & Cressage Medical Practice |

**Online Services Records Access**

**Patient information leaflet ‘It’s your choice’**

**Repeat prescriptions online**

**GP appointments** **online**

**View your GP records**

|  |  |
| --- | --- |
| If you wish to, you can now use the internet to book appointments with a GP, request repeat prescriptions for any medications you take regularly and look at your medical record online\*. You can also still use the telephone or call in to the surgery for any of these services as well. It’s your choice.  Being able to see your record online might help you to manage your medical conditions. It also means that you can even access it from anywhere in the world should you require medical treatment on holiday. If you decide not to join or wish to withdraw, this is your choice and practice staff will continue to treat you in the same way as before. This decision will not affect the quality of your care.  You will be given login details, so you will need to think of a password which is unique to you. This will ensure that only you are able to access your record – unless you choose to share your details with a family member or carer.  **The practice has the right to remove online access to services for anyone that doesn’t use them responsibly.** | **It will be your responsibility to keep your login details and password safe and secure. If you know or suspect that your record has been accessed by someone that you have not agreed should see it, then you should change your password immediately.**  **If you can’t do this for some reason, we recommend that you contact the practice so that they can remove online access until you are able to reset your password.**  **If you print out any information from your record, it is also your responsibility to keep this secure. If you are at all worried about keeping printed copies safe, we recommend that you do not make copies at all.** |

\*Please note that as at 31.3.15 the information available on medical records is restricted to: a summary ` of your medications, allergies and immunisations.

Further information from your medical records may be available in the future, please take this into account when accepting responsibility for the security of the information you view.

|  |
| --- |
| Before you apply for online access to your record, there are some other things to consider. Although the chances of any of these things happening are very small, you will be asked that you have read and understood the following before you are given login details. |

|  |  |
| --- | --- |
| *Things to consider* | |
|  | Forgotten history There may be something you have forgotten about in your record that you might find upsetting. |
| Abnormal results or bad news If your GP has given you access to test results or letters, you may see something that you find upsetting to you. This may occur before you have spoken to your doctor or while the surgery is closed and you cannot contact them. |
| Choosing to share your information with someone It’s up to you whether or not you share your information with others – perhaps family members or carers. It’s your choice, but also your responsibility to keep the information safe and secure. |
| Coercion If you think you may be pressured into revealing details from your patient record to someone else against your will, it is best that you do not register for access at this time. |
| Misunderstood information Your medical record is designed to be used by clinical professionals to ensure that you receive the best possible care. Some of the information within your medical record may be highly technical, written by specialists and not easily understood. If you require further clarification, please contact the surgery for a clearer explanation. |
| Information about someone else If you spot something in the record that is not about you or notice any other errors, please log out of the system immediately and contact the practice as soon as possible. |

|  |
| --- |
| More information For more information about keeping your healthcare records safe and secure, you will find a helpful leaflet produced by the NHS in conjunction with the British Computer Society:  Keeping your online health and social care records safe and secure <http://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Documents/PatientGuidanceBooklet.pdf> |