

**MEADOWGREEN HEALTH CENTRE  
NEW PATIENT HEALTH QUESTIONNAIRE**

To help the practice look after your health care it would assist us if you would answer as accurately as possible a few questions. Your Medical records will come to the practice via the Health Authority and as this process can take several weeks we would appreciate some basic information. Please complete all pages of this questionnaire.

Full Name and Title.....

Address.....

D.O.B..... Telephone Number.....

Sex      M  F       Mobile.....

Occupation.....

Ethnicity..... First Language Spoken.....

Country of Origin..... Religion.....

Height..... Weight.....

A White British	F Blk Oth Non Mix	K Chinese
B White Irish	G Black - other, mixed #	L Oth Ethn Mixed
C White Other	H Indian	M Vietnamese
D Black Caribbean	I Pakistani	N Eth Gp Not Given
E Black African	J Bangladeshi	O Oth Asian Ethn

**Other family members at same address**

NAME	DATE OF BIRTH

**Are you on any repeat medication? Please list all prescription items or attach tear off slip from previous prescription:**

**Are you aware of any drug allergies?**

**Do you have any special communication needs    YES/NO**

Please give information: .....

I am happy for this information to be shared with other healthcare professionals    YES/NO

**Past Medical History. Please give brief details of Operations, Chronic Illnesses and Serious Illnesses:**

<b>Oral contraception Years of use</b>	<b>Mammography Date :</b>
<b>Cervical Smear Date:</b>	<b>Result:</b>
<b>Result</b>	

<b>Dates of other immunisations</b>	<b>Flu</b>
<b>Tetanus</b>	<b>Polio</b>
<b>Rubella</b>	<b>Other Immunisations</b>

Do you normally have a Flu Jab? Yes  No

Are you currently attending any hospital for treatment or do you have a follow up appointment? Please give name of hospital and department and next appointment date.

Hospital.....

Appointment dates.....

Family Medical History	Relative
Coronary Heart Disease <60	
Coronary Heart Disease >60	
CVA /Stroke	
Hypertension	
Diabetes	
Asthma	
Bowel Cancer	
Breast Cancer	
Ovarian Cancer	
Other	

**Smoking Status**

Never smoked

Current cigarette smoker? YES  NO  How many smoked per day? \_\_\_\_\_

Current pipe smoker? YES  NO  How many ounces per day? \_\_\_\_\_

Ex-cigarette smoker? YES  How many smoked per day? \_\_\_\_\_

Ex-pipe smoker? YES  How many ounces per day? \_\_\_\_\_

Would you like help to stop smoking? Yes  No  If so, please speak to reception for advice.

Alcohol	Units/Week
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Diet	Type of Diet	
Pieces of fruit / vegetables	Number/ day	
Exercise	Type	Frequency
Moderate Physical Activity		Frequency

Are you a carer YES  NO  Do you have a carer YES  NO

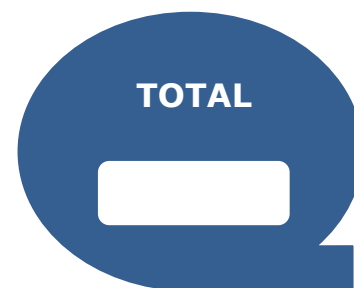
We maintain a carer's register and can offer information and advice. Please speak to a member of the Reception Team for further information.

Please bring a Urine Sample (Container available at reception) to your medical.

**AUDIT – C**

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or 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	
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	

**Scoring:** 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence





## Your emergency care summary

### Summary Care Record – your emergency care summary

The NHS in England is introducing the Summary Care Record, which will be used in emergency care.

The record will contain information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had to ensure those caring for you have enough information to treat you safely.

Your Summary Care Record will be available to authorised healthcare staff providing your care anywhere in England, but they will ask your permission before they look at it. This means that if you have an accident or become ill, the doctors treating you will have immediate access to important information about your health.

Your GP practice is supporting Summary Care Records and as a patient you have a choice: •

- **Yes I would like a Summary Care Record** – you do not need to do anything and a Summary Care Record will be created for you.
- **No I do not want a Summary Care Record** – enclosed is an opt out form. **Please complete the form and hand it to a member of the GP practice staff.**

If you need more time to make your choice you should let your GP Practice know.

For more information talk to GP practice staff, visit the website [www.nhscarerecords.nhs.uk](http://www.nhscarerecords.nhs.uk) or telephone the dedicated NHS Summary Care Record Information Line on 0300 123 3020.

Additional copies of the opt out form can be collected from the GP practice, printed from the website [www.nhscarerecords.nhs.uk](http://www.nhscarerecords.nhs.uk) or requested from the dedicated NHS Summary Care Record Information Line on 0300 123 3020.

**You can choose not to have a Summary Care Record and you can change your mind at any time by informing your GP practice.**

If you do nothing we will assume that you are happy with these changes and create a Summary Care Record for you. Children under 16 will automatically have a Summary Care Record created for them unless their parent or guardian chooses to opt them out. If you are the parent or guardian of a child under 16 and feel that they are old enough to understand, then you should make this information available to them.



**Your emergency care summary**

**CONFIDENTIAL**

**OPT-OUT FORM**

Request for my clinical information to be withheld from the Summary Care Record

If you DO NOT want a Summary Care Record please fill out the form and send it to your GP practice

A. Please complete in BLOCK CAPITALS

Title ..... Surname / Family name.....

Forename(s) .....

Address.....

.....

Postcode ..... Phone No ..... Date of birth .....

NHS Number (if known).....

B. If you are filling out this form on behalf of another person or a child, their GP practice will consider this request.  
Please ensure you fill out their details in section A and your details in section B

Your name.....Your signature .....

Relationship to patient .....Date .....

What does it mean if I DO NOT have a Summary Care Record?

NHS healthcare staff caring for you may not be aware of your current medications, allergies you suffer from and any bad reactions to medicines you have had, in order to treat you safely in an emergency.

Your records will stay as they are now with information being shared by letter, email, fax or phone.

If you have any questions, or if you want to discuss your choices, please:  
 • phone the Summary Care Record Information Line on 0300 123 3020;  
 • contact your local Patient Advice Liaison Service (PALS); or  
 • contact your GP practice.

FOR NHS USE ONLY

Actioned by practice: yes/no

Date .....

Ref: 4705



## NHS Electronic Prescription Service (EPS) Patient Nomination Request

### What is the Electronic Prescription Service (EPS)?

EPS is an NHS-Funded service in England. It gives you the chance to change how your GP sends your prescription to the healthcare professional you choose to get your medication or appliances from.

**Full Name:** .....

**Address:** .....

.....

**Postcode:**..... **Telephone:** .....

**Date of Birth:**..... **Gender:** Male  Female

**Email Address:**.....

**NHS Number:**.....

(This can be found at the top right-hand section of your prescription)

*Please provide your name and address if you are a representative of the patient.*

**Full Name:** .....

**Address:** .....

.....

..... **Postcode:**.....

**Telephone:** .....

### Name and Address of Nominated Dispenser:

.....

..... **Postcode:**.....

- Nomination has been explained to me by staff at my GP practice/community pharmacy/appliance contractor.
- I understand that EPS is an NHS-funded service and the Repeat Prescription Collection Service is a separate service run by the pharmacy.
- I confirm that I have made my nomination of my own free will and have not been influenced or given a gift to select a particular nomination.

I am the patient's parent / guardian.....

I am the patient's representative.....

**Signed:**..... **Date:**..... **Time:** .....

**Print Name:** .....

**Staff Signature:**.....

**Staff Name:** .....