**WELTON FAMILY HEALTH CENTRE – NEW PATIENT QUESTIONNAIRE FOR UNDER 16’s**

Welcome to WELTON FAMILY HEALTH CENTRE. Please help us by completing this questionnaire in full as it may take some time for your medical records to reach us. All information will be treated as strictly confidential and we require you to complete this questionnaire fully before we are able to process your request for registration.

**PERSONAL DETAILS**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **FULL NAME**:  (inc. title) | |  | | | | MALE:  FEMALE: |
| **ADDRESS:**  (inc. postcode) | |  | | | | **Date of Birth**: |
|  | | | | |
| **Mother’s Full Name** | |  | | **Parental Responsibility: Yes**  **No** | | |
| **Father’s Full Name** | |  | | **Parental Responsibility: Yes**  **No** | | |
| **Please give names of any Carers** | |  | | | | |
| **Full Name of Person who you consent to bring your child for treatment if required.** | |  | | | | |
| **Name of School Attended:** | |  | | | | |
| **Please state if the patient has any Social Care Input (eg Family Support Worker: Yes**  **No**  **If YES – Please give details:** | | | | | | |
| **Is Patient Privately Fostered: Yes**  **No** | | | | | | |
| **Home Tel. Number**: |  | | Please **√** if you agree to be contacted by: | | | |
| **Mobile Tel. Number**: |  | | **TEXT** | | **Yes**  **No** | |
| **Email Address**: |  | | **EMAIL** | | **Yes**  **No** | |
| **Work Tel. Number**: |  | |  | | | |

|  |  |
| --- | --- |
| **Previous Doctor’s Name and Address**: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Please tick (√) the box that best describes your ethnic origin.** This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of one of these conditions. | | | | | |
| **WHITE**  White British  White Irish  Any other white background  **MIXED**  White and Black Caribbean  White and Black African  White and Asian  Any other mixed race |  | **ASIAN OR ASIAN BRITISH**  Indian  Pakistani  Bangladeshi  Any other Asian background  **CHINESE**  Chinese  Any other |  | **BLACK OR BLACK BRITISH**  Caribbean  African  Any other black background  **Patient declined** |  |

**P.T.O.**

**PERSONAL HISTORY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Do you have** OR **ever had?:** | **NO**  **√** | **YES**  **√** | **If yes, please give date of diagnosis/event?** |  |
| DIABETES? |  |  |  |  |
| HEART ATTACK? |  |  |  |  |
| ANGINA? |  |  |  |  |
| HIGH BLOOD PRESSURE? |  |  |  |  |
| STROKE/TIA/MINI STROKE? |  |  |  |  |
| HIGH CHOLESTEROL? |  |  |  |  |
| GLAUCOMA |  |  |  |  |
| OTHER? Please give details: | | | | |

|  |  |  |
| --- | --- | --- |
| **Do you currently take any medication?** | **Yes**  **No** | If ‘yes’ please enter details below,: (or bring a list of your medicines) |
| **Name of Medication:** | |  |
|  | |  |
|  | |  |
|  | |  |
|  | |  |

|  |  |  |
| --- | --- | --- |
| **Do you have any allergies or have you ever had a reaction to any medication?** | **Yes**  **No** | **If yes, please give details below** |
|  | | |

**FAMILY HISTORY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Does anyone in your family have:** | **NO**  **√** | **YES**  **√** | **If yes, who?** | **If yes, at what age did they develop the condition?** |
| DIABETES? |  |  |  |  |
| HEART ATTACK? |  |  |  |  |
| ANGINA? |  |  |  |  |
| HIGH BLOOD PRESSURE? |  |  |  |  |
| STROKE/TIA/MINI STROKE? |  |  |  |  |
| HIGH CHOLESTEROL? |  |  |  |  |
| OTHER? Please give details: | | | | |

**P.T.O.**

**VACCINATION HISTORY**

**Please list what vaccinations or immunisations have been given with dates, where known.**

**Please tick who gave the vaccination/immunisation.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Vaccination/Immunisation | Date Given | GP | Baby Clinic | Service Doctor |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Signed on Behalf of Patient: ………………………………………………… Parent/Guardian

PRINTNAME: ……………………………………….. Date: ……………………………………..

**Thank you for helping us by completing this questionnaire. Drs Lumley & Bletcher**

** **

**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: ………………………………………………..…....................................................................

Date of Birth: ………………………………………… Patient’s Postcode: ……………………………………..…….…….

Surgery Name: ………………………………………. Surgery Location (Town): ………...........................…….

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://systems.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 |