

## New Patient Health Questionnaire

### 6 - 15 years

Welcome to Alconbury and Brampton Practice. It may take a while for your records to reach us. Please answer the questions below as this helps us plan your care before your records arrive. Staff are happy to help if you need assistance answering the questions. Please complete **ONE** form using **BLACK INK** for each family member.

#### General Information

Surname:	Title: Master/Miss/Other .....	
First Names:	Preferred Name:	
Date of Birth:	NHS Number:	Gender:
Full Address:		
Home Telephone No:	Mobile No:	
Place of Birth:	Name of School / College:	
Named adult with parental responsibility / next of Kin:		
Relationship to Next of Kin:	Contact Number:	
Religion:		
I give permission for .....who has parental responsibility ..... (please state relationship) to be given details of:		
Next of kin: Yes <input type="checkbox"/> No <input type="checkbox"/> Emergency contact: Yes <input type="checkbox"/> No <input type="checkbox"/> Can discuss Medical Record: Yes <input type="checkbox"/> No <input type="checkbox"/>		
All information Yes <input type="checkbox"/> No <input type="checkbox"/> Signed..... Date: .....		
Siblings (Name and age of brothers / sisters) – please list below		
.....		
.....		
.....		

#### Carer Information

You may not consider yourself a “carer”. However should we need to admit you to hospital urgently, is there someone whose care we would need to consider?

Are you a young Carer: **Yes**  **No**  (if yes, provide name of person you care for / your relationship to person:

Name.....Relationship.....Contact details.....

Would you like us to share your details with our Carer Co-ordinator, who can provide details of local support groups and services: Yes  No

Do you have a Carer: Yes  No  Full name of Carer: Gender:

Relationship to your Carer:.....Your Carers contact number:.....

If applicable, do you consent to your medical record to be discussed with your Carer: **Yes**  **No**

### Medical History

Have you had any major illnesses or major operations? If so, what were they and when?

Diabetes

Asthma

High Blood Pressure

Heart Disease

Cancer

Other, please describe

Vaccinations and Immunisations. Please detail any diseases for which you have been vaccinated or immunised:

### Medication

Are you taking any medication? If so, please list.

If you have a repeat prescription slip from your previous doctor, please attach the repeat slip to this form.

If you previously collected medication, please provide the name of your nominated chemist:

Do you have any allergies (please provide details):

### Family History

Have you or any immediate family members suffered from the following? (Please give the age of diagnosis)

**Heart Attack / Angina:** Yes  No  If YES, Which family member and date?

**Diabetes (Type I or Type II):** Yes  No  If YES, Which family member and date?

**High Blood Pressure:** Yes  No  If YES, Which family member and date?

**Asthma:** Yes  No  If YES, Which family member and date?

**Tuberculosis:** Yes  No  If YES, Which family member and date?

**Stroke:** Yes  No  If YES, Which family member and date?

**Cancer:** Yes  No  If YES, Which family member, date and type of cancer?

**Other serious illness** – please describe:

Are there other factors we should consider when planning your care? EG: disability etc:

### Lifestyle

Height:

Weight:

Do you smoke / vape: Yes  No

Do you consider your diet to be healthy? Eg Low fat, high fibre Yes  No

Do you exercise? Yes  No  If yes, please describe activity, frequency and duration

### Female Patients Only

Have you ever been pregnant? Yes  No  If yes, please give details of pregnancies including dates and outcome (normal delivery, miscarriage etc)

Have you had a contraceptive coil / implant fitted? Yes  No  If yes, please give details / date of fitting:

## Patient Ethnic Origin Questionnaire

Please indicate 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 some of these conditions.

Please tick ONE box to indicate your background.

White British		Irish	
Other White background		White and Black Caribbean	
White and Black African		White and 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	

Please state your first language:

Do you require an interpreter: Yes  No

## Accessible Information Standard

The Accessible Information Standard (AIS) is an NHS England information standard to ensure that people who have a disability, impairment or sensory loss receive information that they can access and understand. For example in large print, braille or via email, and professional communication support if they need it, for example British Sign Language interpreter

Do you require communication to be in Braille? Yes  No

Do you require communication to be in Large Print? Yes  No

Do you require to use a Hearing Loop Yes  No

Do you require communication to be in Audio Tape format? Yes  No

Do you require professional communication support ie British Sign Language or other? Yes  No

If other, please state:

## Preferred Communication Method

Can we contact you by:

Home telephone number: Yes  No

Mobile telephone number: Yes  No

Letter to home address: Yes  No

Please confirm if consent to allowing the Surgery to send text reminders for appointments: Yes  No

# Alconbury & Brampton Surgeries

Alconbury Surgery, School Lane, Alconbury, Huntingdon, Cambs, PE28 4EQ  
Tel 01480 890281 Fax 01480 891787

Brampton Surgery, 69 Miller Way, Brampton, Huntingdon, Cambs. PE28 4RU  
Tel 01480 454050 Fax 01480 455076



Dr D P Rea  
Dr S J Leonard

Dr D P Outram  
Dr P Kooverjee

Dr M Bhimpuria  
Dr L Thompson

Dr S Patel  
Dr E Kiseleva

**Melanie Gearing – Practice Manager**

Dear Patient

You may know that the Government decided that from April 2015, every patient should have a named Doctor. You will be registered with **Dr Thompson or Dr Kooverjee**, although you are free to see whichever Doctor you choose within the Practice.

If you feel strongly that your usual Doctor is a different Doctor within the Practice, please let us know and we will change your medical records accordingly.

We would like to emphasize that you do not always need to see or speak to your usual Doctor in person. You will still be able to see or speak to any of the Doctors in the Practice in the usual way.

Kind regards,

Melanie Gearing  
Practice Manager

## 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 who 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 for adverse reactions only.
- **Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies for adverse reactions and further medical information that includes: your 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.

If you chose not to complete this consent form, a core Summary Care Record (SCR) **will** be created for you, which will contain only medications, allergies and adverse reactions.

Once you have completed the consent form, 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: .....

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
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For more information, please visit <https://www.digital.nhs.uk/summary-care-records/patients>, call 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