Maple Surgery

Patient Health Questionnaire

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| If you need any support completing these forms please ask our reception teams who will be happy to help you. Please ensure you complete the Purple GMS (General Medical services) form clearly at the front of this leaflet. You can obtain your NHS number from your previous GP surgery. We do understand that not all questions on our registration forms are applicable to all patients. However it is important we use the registration process to capture as much information as possible. This is to ensure that we are offering you the best standard of care and can signpost patients who may need extra support at the point of registration. Please complete the registration forms to the best of your knowledge with as much information as possible. |

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| **PATIENT DETAILS** |
| Title………… Full name ……………………………………… Date of Birth ………………….. Address………………………………………………………………………………………………....…………………………………………………………………………………………………………………………………………………………………………………………………………………Telephone (Home)…………………………… Mobile ………………………………..……….....Email ………………………………………………………………………………………………………..  |
| We may use any mobile phone number and email address given to send you a communication about your care e.g. messages and reminders about appointments, test results, or to invite you for an appointment. We will only use these contact details with regard to your care. You do have the right to provide your mobile phone number for calls only. Are you happy for us to contact you by text? YES / NO |

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| **NEXT OF KIN**  |
| Name………………………………………. Relationship…………………………………… Address……………………………………………………………………………………………….. Postcode…………………………………… Telephone……………………………………... |

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| **CARER**  |
| Are you currently a carer for an elderly/chronically ill family member? YES/NO If so, who do you care for? ............................................................................... If you are elderly/chronically ill, do you have a family member who is your carer? YES/NO If so, who is your carer? ................................................................................... |

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| **ACCESSIBLE COMMUNICATION NEEDS** |
| With regards to how we give you information, or communicate with you: Do you have any support needs relating to any disability, impairment or sensory loss? YES / NO If Yes, please tell us what your needs are ……………………………………………………………………………………………... Please let us know how we can best communicate with you and give you information e.g. do you use BSL, large print, Braille or other communication support? ……………………………………………………………………………………………… |

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| **NOMINATED PHARMACY** |
| Which pharmacy would you like your electronic prescriptions to go to? ………………………………………………………………………………………………………… |

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| **SUMMARY CARE RECORD**  |
| Today, records are kept in all the places where you receive care. These places can usually only share information from your records by letter, email, fax or phone, which can at times, slow down treatment. Summary Care Records have been introduced to improve the safety and quality of your care. Because this is an electronic record it will give healthcare staff faster, easier access to essential information about you, to help provide you with safe treatment when you need care in an emergency or when we are closed. Your Summary Care Record will contain important information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines that you have had. It will also include your name, address, date of birth and your unique NHS Number to help identify you correctly. **As a patient you have a choice. Please select one of the following**. □ **Yes I would like a summary care record** - you do not need to do anything else □ **No I do not want a summary care record** – Please complete an opt-out form. This is available at Reception if you don’t already have one.  |
| **Your Health Record and sharing of information – please read and select your options below.** Your health record includes medical history, medication and any allergies you may have. You can now choose whether to share these full medical details. We use a secure electronic health records system called SystmOne. With your permission, this system can allow clinicians to share the record held here with other healthcare services that you may need to use e.g. out of hours services, children’s services and community services. These other services will ask your permission to view the record. You have two choices, which allow you to control how your record is shared and you can change these choices at any time by letting the relevant practice or service know. **SHARING OUT** – This controls whether record information recorded at this practice can be shared with other healthcare service e.g. the out of hours service. Please select one of the options below. **I would like my health record at this practice or service to be shared with other healthcare services providing care for me YES NO** **SHARING IN** – This determines whether or not this practice can view information in your record entered by other services. Please select one of the options below. **I would like this practice to be able to view information in my health record that has been recorded by other healthcare service. YES NO** |

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| **MAIN LANGUAGE**  |
| Which language is your main spoken language? …………………………………………………………………………… |

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| **ETHNICITY**  |
| Information on ethnicity is important because of the need to take into account culture, religion and language in providing appropriate care, as well as the clinical benefits as some diseases are more common in some ethnic groups. Please select one of the following **What is your ethnic group?** Choose ONE section from A to E, then tick the appropriate box to indicate your cultural background. **a. White** British □ Irish □ Scottish □ Any other white background, *please write in…………………………………………………....* **b. Mixed** White and Black Caribbean □ White and Black African □ White and Black Asian □ Any other mixed background*, please write in………………………………………………........* **c. Asian or Asian British** Asian British □ Indian □ Pakistani □ Bangladeshi □ Any other Asian background*, please write in……………………………………………………* **d. Black or Black British** Black British □ Caribbean □ African □ Any other Black background, *please write in……………………………………………………* **e. Chinese and other ethnic group** Chinese □ Any other, *please write in………………………………………………………………………………………………………………..* |

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| **PERSONAL MEDICAL HISTORY** |
| ANGINA | ARTHRITIS | ASTHMA |
| CANCER | DIABETES | EPILEPSY |
| HIGH BLOOD PRESSURE | LEARNING DISABILITIES | OSTEOPOROSIS |
| MENTAL HEALTH ISSUES | SKIN DISEASE | THYROID DISEASE |
| COPD | OTHER |  |
| Please list the medications you take: |

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| **FAMILY MEDICAL HISTORY** |
| HEART PROBLEMS (i.e. ANGINA/HEART ATTACK) | YES / NO | RELATIONSHIP / AGE: |
| STROKE (CVA) | YES / NO | RELATIONSHIP / AGE: |
| CANCER | YES / NO | RELATIONSHIP / AGE: |
| DIABETES | YES / NO | RELATIONSHIP / AGE: |
| ASTHMA | YES / NO | RELATIONSHIP / AGE: |

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| **ALCOHOL STATUS**  |
| **Do you currently drink alcohol? YES/NO** |
| Questions | Scoring scheme  | Your score |
| 0 | 1 | 2 | 3 | 4 |
| 1. How often do you have 8 drinks (for a man) or 6 drinks (for a woman) on one occasion.  | Never  | Less than monthly  | Monthly  | Weekly  | Daily or almost daily  |  |
| **Only consider the following questions if the above question scored 2 or more.** |
| 2. How often during the last year have you been unable to remember what happened the night before because you had been drinking?  |  |  |  |  |  |  |
| 3. How often during the last year have you failed to do what is normally expected of you because of your drinking?  |  |  |  |  |  |  |
| . In the last year has a relative or friend, or a doctor or health worker been concerned about your drinking or suggested you cut down?  |  |  |  |  |  |  |
| Total |  |

Total >= 3 is positive – patient should be offered full screening test

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| **SMOKING STATUS** |
| **Section 1** Do you currently smoke? YES/NO …………. **If NO, go to section 2 If YES, please go to section 3** |
| **Section 2 (**Please fill this section in if you do NOT currently smoke.) Have you ever smoked? YES/NO …………. **If YES,** at what age did you start smoking? ……… When did you stop smoking? ................ |
| **Section 3** (Please fill this section in if you are a current smoker) Would you like to give up smoking? YES/NO? |
| **Smoking Advice** As you may know, there are many health risks involved in smoking, e.g. smoking just one cigarette a day trebles your risk of lung cancer and raises the risk of chronic lung disease, as well as cancer of the mouth, throat, bladder, pancreas and many more. There are also many health benefits to those who give up, for your health, your family and also your wallet! Here at the surgery we can help you to quit, offering advice plus NHS prescriptions for nicotine patches, gum etc. If you want to quit, even if you have tried many times before, please call the surgery to book an appointment with our Health Care Assistant.  |
| **TO BE COMPLETED FOR UNDER 17 YEAR OLDS** |
| The Child and Family Health Team (Health Visitor and School Nursing Service) like to make contact with the parents/ caregivers for those under 17 who have recently registered at the surgery. Please complete your child’s details below and we will send it onto the Child and Family Health Team |
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| Surname |
| Forenames |
| Date of Birth | Gender M/F |
| New Address | Previous Address |
| New contact number(s) |
| Is your child up to date with immunisations? | Yes/No |
| When did your child last have a development assessment? |  |
| Does your child have any physical or learning difficulties? |  |
| Would you like the Child and Family Health Team to contact you? |  |
| If contact is not required, the Child and Family Health Team will send you details of clinics and local activities that may be of interest to you |  |

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| **CONTRACT OF CARE** |
| The GPs, Nurses, Practitioners and Staff aim to provide the highest possible care to our patients. The aim of this Contract of Care is to ensure that you understand the practice policies, why such policies are in place and then follow them. We particularly recommend that you read closely the details relating to our Appointment, Repeat Prescribing and Behaviour expectations. |
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| Your responsibilities: | Practice responsibilities: |
| Comply with recommended treatment | Offer access to quality medical services |
| Participate in appropriate screening and prevention programmes | Provide you with an appointment with a GP or appropriate healthcare professional or signpost you to a suitable alternative service in line with our appointments procedure |
| Commit to a healthy lifestyle with support from the Practice if required. | Enable you to relevant appointments with the right clinician the first time |
| Treat clinicians and staff with dignity and respect at all times. | Treat you with dignity and respect at all times. |
| Be aware of our practice booking system and use this appropriately and book with the appropriate clinician. | Ensure all patients have access to a patient information leaflet which includes information of how to book an appointment |

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| Information about all the services we provide are detailed on our website If you do not have access to the internet please ask at reception for a practice leaflet. Before deciding that you wish to join the Practice we ask that you review this information in order to decide whether you can follow the policies presented by the Practice in line with the General Medical Services GP contract. |

**MAPLE SURGERY**

**Accessing GP Records Online - Patient Leaflet**

Practices are increasingly enabling patients to be able to request repeat prescriptions and book appointments online. Some patients may wish to access more information online and contractually from 1st April 2015 practices are obliged to assist access to medications, allergies and adverse reactions as a minimum and from the 1st April 2016 coded data.

However this requires additional considerations as outlined in this leaflet. You will be asked that you have read and understood this leaflet before consenting and applying to access your records online. The practice will also need to verify your identity.

Please note:

* 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.
* The practice may not be able to offer online access due to a number of reasons such as concerns that it could cause harm to physical or mental health or where there is reference to third parties. The practice has the right to remove online access to services for anyone that doesn’t use them responsibly.

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

**APPLICATION FOR ONLINE ACCESS TO MY RECORD**

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| I wish to have access to the following online services (please tick all that apply): |
| 1. Booking appointments 2. Requesting repeat prescriptions 3. Limited access to parts of my medical record  |
| I wish to access my medical record online and agree with each statement below (tick): |
| 1. I have read and understood the information provided by the practice 2. I will be responsible for the security of the information that I see or download 3. If I choose to share my information with anyone else, this is at my own risk 4. I will contact the practice as soon as possible if I suspect that my accounthas been accessed by someone without my agreement 5. If I see information in my record that is not about me or is inaccurate, I willcontact the practice as soon as possible 6. I agree to provide the surgery with photo ID to allow my identity to be verified Signature…………………………………….. Date…………………………………………… |
| For practice use only |
| Method of verification: Vouching  Vouching with information in record Photo ID and proof of residence  Date of Verification………………………………………. |