ROTHWELL & DESBOROUGH HEALTH CARE GROUP

Health Questionnaire

Thank you for applying to join Rothwell & Desborough Health Care Group. As a new patient to the practice we would like to ask you to complete the following questionnaire. This will assist in providing you with the best care. You must sign the form on the final page to confirm all the details given are correct. **All information given to us will be confidential and used only in accordance with statutory regulations, e.g. Data Protection Act.**

UK residents and those residing in the UK for legal and settled purpose, AND living within the practice area, are entitled to register with us. UK citizens who now live abroad for most of the year may not entitled to free NHS care. European Economic Area (EEA) rules apply for those residing in a member state.

Please complete all areas in CAPITAL LETTERS

Personal Details

Title:	Surname:	First name(s):
NHS no:	Date of Birth:	Male ☐ Female ☐
Home address: Postcode:	Town and country of birth: Single ☐ Cohabiting ☐ Widowed ☐ Married ☐ Divorced ☐ Separated ☐ Civil Partnership ☐	
Home telephone no:	Work telephone no:	
Mobile telephone no:	E-mail address:	
Occupation:	Retired ☐ Unemployed ☐	
Are you in the Armed Forces or a Reservist? Yes ☐ No ☐	Are you a Military Veteran? Yes ☐ No ☐	

Previous address and doctor's details

Previous address in the UK: Postcode:	Name or previous doctor: Address of previous doctor:

Next of kin

Name of next of kin:	Relationship to you:
Next of kin telephone number:	Next of kin address (if different to above):

Ethnic Group

White	☐ British	☐ Irish	
Black	☐ Caribbean	☐ African	
Mixed	☐ White & Black Caribbean	☐ White & Black African	☐ White & Asian
Asian	☐ Indian	☐ Pakistani	☐ Chinese
Other	*Please specify:*		

Name: _____ Date of Birth:_____

First Language	**Religion:**
English: ☐ Other:	What is your religion:

Height:	**For women only**			
	Have you had a hysterectomy?	☐ Yes	☐ No	Date:
Weight:	Have you had a mammogram?	☐ Yes	☐ No	Date:
	Have you had a cervical smear?	☐ Yes	☐ No	Date:
	Do you have a Coil (IUCD) or Contraceptive Implant fitted?	☐ Yes	☐ No	Type of Coil & Date fitted:
Blood Pressure (16yrs and older) – please attach a read-out from the surgery BP machine located near the waiting area (ask reception for the location if you are unsure)				

Family history	**Please tick**	**Which family member(s)**
Heart Attack / Angina	☐	
High Blood pressure	☐	
Low blood pressure	☐	
Stroke / Mini-stroke (TIA)	☐	
Diabetes	☐	
Glaucoma	☐	
Asthma	☐	
Eczema	☐	
Hay fever	☐	
Cancer	☐	
Thyroid Disorder	☐	
Peptic ulceration	☐	
Depression	☐	
COPD	☐	

Do you suffer/have suffered in the past from any of the following (please tick)

☐ **Asthma**	☐ **Diabetes**	☐ **Epilepsy**
☐ **COPD**	☐ **Stroke**	☐ **Learning Disability**
☐ **High Blood Pressure**	☐ **Heart Failure / Angina**	

Are you allergic to any medicine or other substance? If yes, please list below

1.	4.
2.	5.
3.	6.

Lifestyle :

How would you describe your diet?	**What are your exercise habits?**	
☐ Good diet	☐ Exercise impossible	
☐ Average diet	☐ Light exercise	In what form:
☐ Poor diet	☐ Moderate exercise	In what form:
☐ Vegetarian / Vegan	☐ Heavy exercise	In what form:

Name: _____ Date of Birth:_____

Please tell us about you alcohol consumption

1 unit of alcohol = 1 standard drink e.g.

- **Half pint of normal-strength beer, lager or cider (4% abv).**
- **Half a 175ml glass of average-strength wine (12.5% abv).**
- **One single (25ml) measure of spirits (40% abv)**

	Scoring System					Score
Question	**0**	**1**	**2**	**3**	**4**	
How often do you have a drink that contains alcohol?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How many units of alcohol do you drink on a typical day when you are drinking?	1-2 drinks	3-4 drinks	5-6 drinks	7-8 drinks	10+ drinks	
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 in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or someone else been injured as a result of your drinking?	Never		Yes, but not in the last year		Yes, during the last year	
Has a friend / relative / doctor / health worker been concerned about you drinking or advised you to cut down?	Never		Yes, but not in the last year		Yes, during the last year	
					Total	

Please tell us about your smoking habits

Do you smoke? ☐ Yes ☐ No - *If yes, how many per day* _____

Are you an ex-smoker? ☐ Yes ☐ No - *If yes when did you stop?* _____

Name: _____ Date of Birth:_____

On-line account

I wish to have access to the following online service (tick all that apply)	
1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. Accessing my medical records	☐

Application for online access to my medical record

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

1. I have read and understood the information leaflet 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 account has been accessed by someone without my agreement	☐
5. If I see information in my record that is not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible	☐

Text reminders for appointments

Would you like to receive text reminders for appointments?	Yes ☐	No ☐

I consent to the practice contacting me by text message and/or e-mail for the purposes of health promotion, practice news and appointment reminders. I acknowledge that the appointment reminders by text are an additional service and that they may not be sent on all occasions and the responsibility for attending appointments or cancelling them still rests with me. I can cancel the text message facility at any time. Text messages are generated using a secure facility but I understand that they are transmitted over a public network onto a personal telephone and as such may not be secure; however, the practice will not transmit any information which would enable an individual patient to be identified. **I agree to advise the practice if my mobile number changes or if it is no longer in my possession. If I have not informed the practice of a change then I take full responsibility for the practice sending a text to this number if it is no longer used by me.**

Opt Out Forms

Your information can be shared with other organisations, for further information regarding this you can visit our website at www.rdhg.co.uk Please indicate if you would like to opt in our out of any data sharing. If you opt out, please ensure you complete the separate opt out forms available.

Are you opting out of the 'Summary Care Record'?	Yes ☐	No ☐
Are you opting out of the 'Care Data' scheme?	Yes ☐	No ☐

Practice Newsletter

Would you like to receive our Quarterly Practice Newsletter? (Please ensure you have given us you e-mail address to subscribe to this)	Yes ☐	No ☐

Electronic Prescription Service (EPS)

We now offer an Electronic Prescription Service. To sign up to EPS speak to member of staff or a Pharmacy of your choice. The will remove the need for paper prescription. Your request will automatically be sent to your nominated pharmacy.

Name and address of nominated Pharmacy:

Signed:	Date:

Name: _____ Date of Birth:_____

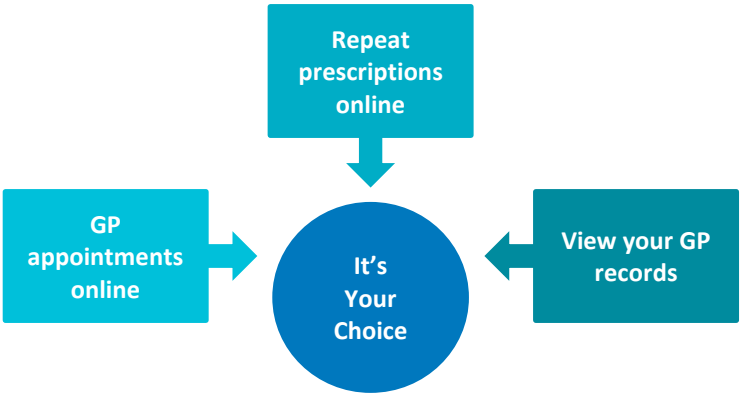
ROTHWELL & DESBOROUGH HEALTH CARE GROUP

Online Services Records Access
Patient information leaflet 'It's your choice'

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.



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 has the right to remove online access to services for anyone that doesn't use them responsibly.

Name: _____ Date of Birth:_____ 28.4.2017

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

Name: _____ Date of Birth:_____

ROTHWELL & DESBOROUGH HEALTH CARE GROUP

ROTHWELL MEDICAL CENTRE
109 Desborough Road
Rothwell Northants
NN14 6JQ

Tel: 01536 211277
Fax: 01536 714189

DESBOROUGH SURGERY
35 High Street
Desborough Northants
NN14 2NB

Tel: 01536 760345
Fax: 01536 763281

Website: www.rdhg.co.uk

CHILDREN UNDER 16

Please complete all areas in CAPITAL LETTERS

Personal Details

Title:	Surname:	First name(s):
Date of Birth:		Male ☐ Female ☐
Home address: Postcode:		
Parent / Carer:		
Name of Mother:		Telephone no:
Name of Father:		Telephone no:
Name of Carer:		Telephone no:

Any other adults (Ex-partner, Grandparent, etc.) who have long-term care for the child? ☐ Yes ☐ No

Name:	Relationship:	Telephone no:
Name:	Relationship:	Telephone no:

Does the child have a Social Worker? ☐ Yes ☐ No

Name of Social Worker:	Contact Details:

Are there any other Agencies involved in their care? ☐ Yes ☐ No

Name:	Contact Details:
Name:	Contact Details:

LETTING YOUR GP KNOW YOU ARE A CARER

(This does not include people employed to provide care)

Does someone at home or in the neighbourhood depend on you to help with the tasks and/or responsibilities of everyday living? If so, you are a carer and might like some support for yourself.

You may see it as part of your life or your duty to care for your Mum, Dad, your partner, your child or friend, but there may be times when you need information, advice or some extra help.

When you are a carer it is often difficult to have a real break because someone depends on you to look after them. You can get tired and run down, and your health could suffer. Telling your surgery can help them to support you. If you want your doctor to know that you are a carer, fill in the form below and your name can be added to the carers' register.

Carers' Register

I am a carer. I want my name to go onto my GP's Carers' Register and give permission for this to be noted on my medical records.

My Name: …….

My Address: ……..
……

Signature: ……. **Date:** …….

My GP Surgery is: ……

I care for the following:
Name(s): ……

The person/ people I care for is/are my ……
Parent(s)☐ Parent(s)-in-law☐ Husband☐ Wife☐ Partner☐ Daughter☐ Son☐
Other Family Member☐ Friend☐ Neighbour☐ (Please tick the relevant box)

The person I care for is registered with the same practice as I am: Yes☐ No☐
If No, please give the address of the surgery or the name of the GP who treats the person you care for:
……

We will refer you to the Carers Service (Northamptonshire Carers) for further information and support. Please tick if you do NOT wish to be referred ☐
Northamptonshire Carers provides information and advice and free services such as gym sessions, sitting service, holidays and emotional support.

Name: _____ Date of Birth:_____

Care.data: Opt-Out Form

If you would like more information about the care.data programme and/or you need some assistance with making your decision please contact the national patient data sharing helpline on 0300 456 3531

Please tick one or both options below:

☐ I do NOT want my personal confidential data to be released by my GP surgery for the care.data programme. Please add the code XaZ89 'Dissent from secondary use of GP patient identifiable data'

☐ I do NOT want my personal confidential data from hospitals and other care providers to be released by the Health & Social care Information Centre (HSCIC) for the care.data programme. . Please add the code XaaVL 'Dissent from disclosure of personal confidential data by Health and Social Care Information Centre'.

Section A: It is important that you complete this section accurately and please use BLOCK CAPITALS

Title	
Forename	
Surname	
Address	
Phone No.	
Date of Birth	
NHS Number (if known)	
Patient's signature	
Date	

If you are filling out this form on behalf of another person or child, their GP practice will check that you have the authority to do so. Please ensure you fill out their details in section A and your details in section B.

Section B:

Your name	
Relationship to patient	
Your signature	
Date	

*** Please return this completed form to your GP surgery (or the patient's registered GP surgery if you are completing this form for somebody else) ***

For GP Practice use only:

9Nu0/XaZ89 added Y/N	
9Nu4/XaaVL added Y/N	
Initials	
Date	

Name: _____ Date of Birth:_____

For practice use only

For a patient to register with the practice they must be Resident in the UK and living within our Practice Boundary. 1 photo ID and 1 document with name AND address, the same as being registered, must be provided.

Evidence to support application must be relevant to the Patient Only (NOT other family members):

You must verify A plus B, C or D

A

Evidence of Address – UK resident	Identity Verified by (Initials) & Date
Tenancy Agreement / Mortgage Statement	
Wage Slip / Bank Statement / Loan Account/Photo Driving Licence	

In addition, one of the following is required:

B

Evidence of Identity – UK resident (Photo ID)	Identity Verified by (Initials) & Date
Passport	
Photo Driving Licence / Photo Identity card	

C

Evidence of Status – Patients outside the EEA	Identity Verified by (Initials) & Date
Visa	
Resident Permit for more than 6 months	

D

Evidence of Status – Patients within the EEA	Identity Verified by (Initials) & Date
Passport	
Identity Card / Birth Certificate	

Please check that the following has been returned:

GMS1 Form	☐
Care.data Opt Out Form	☐
Summary Care Opt Out Form	☐
Health Questionnaire	☐
Children Under 16 Form (if Applicable)	☐

Once the registration has been added to SystmOne forward **all documents** to the QOF/Audit Team.

N.B Each new patient registration pack should contain:

- GMS 1 Form
- Care.data Opt Out Form
- Summary Care Opt Out Form
- Health Questionnaire
- Patient Online Leaflet
- Children Under 16 Form (If applicable)

Name: _____ Date of Birth:_____