|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Central and Thorpe Surgery**  **NEW PATIENT INFORMATION CARD** | | | | | | | | DATE: | | | |  | | | | | | | | |
| **PLEASE FILL IN ALL BOXES IN BLOCK CAPITALS ONLY** | | | | | | | | | | | | |
| Surname: | | |  | | | | | | | | | | Title: |  | | | | | | |
| Forename(s): | | |  | | | | | | | | | | | | | | | | | |
| Date of birth: | | |  | | | | NHS No.: | | | | | | | |  | | | | | |
| Place of Birth: | | |  | | | | Sex : | | | | | | | | MALE / FEMALE | | | | | |
| Marital Status: | | |  | | | | Maiden name: | | | | | | | |  | | | | | |
| **Ethnicity:** | | |  | | | | First Language: | | | | | | | |  | | | | | |
| Occupation: | | |  | | | | | | | | | | | | Are you a carer? | | | | | YES / NO |
| Full address: | | |  | | | | | | | | | | | | | Postcode: | | | | |
| Nominated Pharmacy: | | | | |
| Tel No (Home): | | |  | | | | | | | Mobile No: | | | | | | |  | | | |
| **Religion** | | |  | | | | | | |
| **Would you like to receive appointment reminders, test results, invites in regards to your health via text message YES/NO** | | | | | | | | | | | | | | | | | | | | |
| Next of Kin | | |  | | | | | | Telephone no | | | | | | | |  | | | |
| If patient still in education – name of school/college/university | | | | |  | | | | | | | | | | | | | | | |
| YOUR EMAIL ADDRESS: | | | | |  | | | | | | | | | | | | | | | |
| **PREVIOUS DETAILS** | | | | | | | | | | | | | | | | | | | | |
| Previous address: | |  | | | | | | | | | | | | | | Postcode: | | | | |
|  | | | | |
| Previous Doctors Name & Address: | |  | | | | | | | | | | | | | | | | | | |
| **GENERAL MEDICAL HISTORY** | | | | | | | | | | | | | | | | | | | | |
| Have you had or suffer from any medical conditions, illnesses or had any operations or x-rays or similar tests done and when? | | | | | | | | | | | | | | | | | | | | |
| **□ Asthma** | **□ Diabetes** | | | **□ Hypertension** | | **□ COPD** | | | | | **□ Epilepsy** | | | | | | | **□ Heart Failure** | **□ Atrial Fibrillation** | |
| **□ Depression** | **□ Cancer** | | | **□ Hypothyroidism** | | **□ Dementia** | | | | | **□ Chronic Kidney Disease** | | | | | | | **□ Coronary Heart Disease** | **□ Stroke/TIA** | |
| Are you taking any form of medications, if so what are the names and dosages? | | | | | | | | | | | | | | | | | | | | |
| Have you any allergies to medicines or anything else? | | | | | | | | | | | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **The Summary Care record (SCR)** is a summary or patient’s Allergies & medication uploaded to the Spine so that it can be accessed by any legitimate carer, regardless of the computer system they use. The circumstances when this is beneficial include when a patient is seen at a hospital or Out of Hours unit or were a temporary resident is seen at a GP practice. You can choose to opt out of SCR should you not wish this information to be shared.  Would you like to opt out of The Summary Care Record? **Yes / No** | | | | | | | | | | | | | | |
| **Would you like to sign up to our online services for booking appointments & requesting medication Yes/No** | | | | | | | | | | | | | | |
| How much tobacco/cigarettes do you smoke? | | | | | | | |  | | | | Per Day / Week | | |
| How often do you have a drink containing Alcohol | | | |  | | | | | | | How many units do you drink on a day typical day when you are drinking | | |  |
| How often have you had 6 or more standard drinks if female or 8 or more if male | | | | |  | | | | Do you have a dependency to alcohol | | | |  | |
| **FAMILY HISTORY** – Which of **YOUR BLOOD RELATIONS** have suffered from the following : | | | | | | | | | | | | | | |
| **□ Heart Attack** |  | | | **□ Cancer** | |  | | | | **□ Diabetes** | |  | | |
| **□ High Blood Pressure** |  | | | **□ Asthma** | |  | | | | **□ Tuberculosis** | |  | | |
| **□ Stroke** |  | | | **□ Other** | | **□ Hyperthyroidism** | | | | | | **□ Epilepsy** | | |
| **VACCINATIONS – Which vaccinations have you had and when?** | | | | | | | | | | | | | | |
| **□ Hib/Dip/Polio/Tet** | |  | | **□ Polio** | |  | | | | **□ Hep A** | |  | | |
| **□ Tetanus** | |  | | **□ Typhoid** | |  | | | | **□ Hep B** | |  | | |
| **□ Yellow Fever** | |  | | **□ MMR** | |  | | | | **□ BCG** | |  | | |
| **□ Influenza** | |  | | **□ Pneumonia** | |  | | | | **□** | |  | | |
| For infants under 5 years of age – Are they up to date with their immunisations? YES / NO | | | | | | | | | | | | | | |
| **FOR FEMALE PATIENTS ONLY** | | | | | | | | | | | | | | |
| Have you had any children | | | | YES / NO | | Ages: | | | |  | | | | |
| Have you had any problems with previous pregnancies or any miscarriage or termination? | | | |  | | | | | | | | | | |
| Have you had a hysterectomy? | | | | YES / NO | | | Date: | | |  | | | | |
| Which method of contraception are you using at present? | | | | | | |  | | | | | | | |
| Date of last smear test: | | |  | | | | | | | | | | | |
| Do you have any communication or information needs relating to a disability, impairment or sensory loss, if so what are they? | | | | | | | | | | | | | | |
| Office use only | | | | | | | | | | | | | | |
| Date Received |  | | | | | | Details: | | | | | | | |