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| **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? |

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| **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: |