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| **1. Background Details** | | | | | | | | | |
| **Contact Details** | | | | | | | | | |
| NHS Number |  | | | | | *If you have had a previous GP then you will find this on letters/prescriptions or at* [*www.nhs.uk/find-nhs-number*](https://eur01.safelinks.protection.outlook.com/?url=http%3A%2F%2Fwww.nhs.uk%2Ffind-nhs-number&data=04%7C01%7Csupport%40ardens.org.uk%7Cffabf11787fb41dc43be08d99fa70d67%7C2574bae132844b5a8833850acab88d43%7C1%7C0%7C637716362095841893%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=MF3g4y6zrx4E0Qifat%2FgKNmjXrzmgNeU5ebPuaEcNAo%3D&reserved=0) | | | |
| Name |  | | | Pronoun | | | Gender |  | |
| Which of the following best describes how you think of yourself? | Non-binary  Female  Male  Prefer not to say  Unable to answer | | | | | | | | |
| Is your gender the same as the sex you were assigned at birth? | Yes  No | | Prefer not to say.  Unable to answer | | | | | | |
| Previous Surname  (if applicable) |  | | | | | | | | |
| Address |  | | | | | Date of Birth | |  | |
| Home Telephone | |  | |
| Work Telephone | |  | |
| Previous Address |  | | | | | | | | |
| Mobile Telephone | I consent to be contacted\* by SMS on this number: | | | | | | | | |
| Email | I consent to be contacted\* by email at this address: | | | | | | | | |
| Next of Kin | Name: | | | | Tel: |  | | Relationship: |  |
| Family Registered With Us | |  | | | | | | | |
| Has the patient been registered in the NHS before?  Yes  No  If no please state date entered UK: | | | | | | | | | |

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| **Other Details** | | | |
| Previous GP | Name: | Address: |  |
| Country of Birth |  | | |
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| Previous GP | Name: | | Address: |  | |
| Country of Birth |  | | | | |
| Ethnicity | White (UK)  White (Irish)  White (Other) | Black Caribbean  Black African  Black Other | | Bangladeshi  Indian  Pakistani | Chinese  Other |
| Religion | C of E  Catholic  Other Christian | Buddhist  Hindu  Muslim | | Sikh  Jewish  Jehovah’s Witness | No religion  Other: |
| Overseas Visitor | Yes | European Health Insurance Card Held (please bring details with you) | | | |
| **Communication Needs** | | | | | |
| Language | What is your main spoken language?  Do you need an interpreter?  Yes  No | | | | |
| Communication | Do you have any communication needs?  Yes  No (If **Yes** please specify below) | | | | |
| Hearing aid  Lip reading | Large print  Braille | | British Sign Language  Makaton Sign Language  Guide dog | |
| Learning disability | Do you have a Learning Disability?  Yes  No  (If **Yes** please request a Learning Disability Screening Tool form) | | | | |

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| Reasonable Adjustments are changes we (and other organisations that are involved in your care) can make, so that care is as accessible to you as for people who do not have a disability or impairment. Some examples of Reasonable Adjustments are given below. Please tick if these apply to you or use the "other" option if this is more appropriate for you. If you would like any help or support in completing this section, please let us know.  **When I attend a health appointment** **I may need:**   * My Carer to stay with me. * A longer appointment * Help with physical examination. * Help to have a blood test/injection. * Easy-read information * Changes to the environment e.g., quieter room, dimmed lighting. * Desensitization visits * Support with consent to treatment * Make use of technology e.g., communication aids, I-pads, zoom, Teams. * Other   I agree to have my information stored in my local records, and I give permission to my GP surgery to share this information with other organisations responsible for my care, through the NHS Spine. Only the individuals who need to know what reasonable adjustments I require will be able to access this information, and it will be kept safe and protected  Yes |

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| **Carer Details** | | | | | |
| **Are you** a young carer? | Yes – Informal / Unpaid Carer | |  | | No |
| Do you **have** a carer? | Yes | Name\*: | Tel: | Relationship: | |

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| **2. Medical History** | | | |
| **Medical History** | | | |
| Have you suffered from any of the following conditions? | | | |
| Asthma  COPD  Epilepsy | Heart Disease  Heart Failure  High Blood Pressure | Diabetes  Kidney Disease  Stroke | Depression  Underactive Thyroid  Cancer- Type: |
| Any other conditions, operations or hospital admission details:  **If you are currently under the care of a hospital or Consultant outside our area, please tell us here:**  **If you, or anyone you live with are currently under the care of the following, please let us know:**  Adult/Child Safeguarding Team  Social Services Team  Children & Young People Services  Other, please state: | | | |

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| **Allergies** |
| Please record any allergies or sensitivities below |

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| **Family History** | | | |
| Please record any significant family history of close relatives with medical problems and confirm which relative e.g. mother, father, brother, sister, grandparent | | | |
| Asthma………………….  COPD………………...…  Epilepsy………………… | Heart Disease……….…  Stroke…………….……..  Blood Pressure………… | Diabetes………..………  Kidney Disease..………  Liver Disease..….…….. | Depression………..……  Thyroid…………..….…..  Cancer………………….. |
| Other: | | | |

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| **Current Medication - Please let us know if you need medication urgently when joining as a new patient** |
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| **Smoking** | | | |
| Do you smoke? | Never smoked | Ex-smoker | Yes |
| Do you use an e-Cigarette? | No | Ex-User | Yes |
| How many cigarettes did/do you smoke a day? | Less than one | 1-9 10-19 | 20-39  40+ |
| Would you like help to quit smoking? | Yes | No |  |
|  | For further information, please see: [www.nhs.uk/smokefree](http://www.nhs.uk/smokefree) | | |

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| **Electronic Prescribing** | |
| If you would like your prescriptions to be sent electronically,  please provide details of the pharmacy you would like to use: | Pharmacy: |

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| **Your Health Record** |
| Do you consent to your GP Practice sharing your health record with other organisations who care for you?  Yes *(recommended option)*  No, never  Do you consent to your GP Practice viewing your health record from other organisations that care for you?  Yes *(recommended option)*  No |

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| **Your Summary Care Record (SCR)** |
| Do you consent to having an Enhanced Summary Care Record with Additional Information?  Yes (*recommended option)*  No |

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| **Signatures** | |
| Signature | I confirm that the information I have provided is true to the best of my knowledge.  Signed on behalf of patient |
| Name |  |
| Date |  |

**To be completed by GP/Admin only**

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| Form reviewed by: | Appointment Required Yes  No |
| Patient contacted: | Appointment arranged date: |