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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 [ ]  NoIf 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, neverDo 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:  |