*Please fill in this form to the best of your ability. It will help us until we receive a medical record and acts as a useful aid to the healthcare of the patient.*

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | | |
| Date of Birth |  | | |
| Address |  | | |
|  |  | | |
|  |  | | |
|  |  | | |
|  |  | | |
| Home Telephone Number | | |  |
| Mobile Telephone Number | | |  |
| Email Address | | |  |
|  | | |  |

Do you wish to be exempted from the practice sending you text messages (appointment reminders, etc.)?

|  |  |
| --- | --- |
| Yes | No |

Do you have a nominated pharmacy for electronic prescriptions?

|  |
| --- |
|  |

Do you have access to a car?

|  |  |
| --- | --- |
| Yes | No |

Name of School (if child is of school age)

|  |
| --- |
|  |

|  |  |  |
| --- | --- | --- |
| Name of Parent/s or Guardian/s with Parental Responsibility |  |  |
| Date of Birth of Parent/s or Guardian/s with Parental Responsibility |  |  |

**NHS England: Summary Care Record**

Summary Care Records are used in emergency care and contains information such as any medication you are taking, allergies that you suffer from and any bad reactions to medicines you have had, to ensure those caring for you have enough information to treat you safely.

***If you would like to opt out of having a Summary Care Record then please ask for the opt-out form at reception. For more information regarding Summary Care Records you can call the dedicated NHS Summary Care Record Information Line on 0300 123 3020 or visit www.nhscarerecords.nhs.uk.***

**Health Questionnaire**

Current Medication

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |

Allergy to any drugs?

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| Has he or she had any serious illnesses or operations? |  |  |  |

**For those under 6 months only:**

|  |  |
| --- | --- |
| Birthweight (lbs & oz) |  |
| Type of Delivery | Normal / Forceps / Caesarean |
| Current Feeding | Breast / Bottle / Both |
| Started Immunisation Course? | Yes / No |
| If immunisation course has been started was it with or without the Whooping Cough Vaccine | With / Without |

**For those six months to school age only:**

Immunisations (Please circle whether the following have been completed)

|  |  |
| --- | --- |
| Basic Course of 3 Diphtheria / Tetanus / Polio | Yes / No |
| Basic Course of 3 Diphtheria / Tetanus / Whooping Cough / Polio | Yes / No |
| Measles | Yes / No |
| Preschool Booster of Diphtheria / Tetanus / Polio | Yes / No |
| Meningitis | Yes / No |

**Patient Ethnic Origin Questionnaire**

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

|  |  |  |
| --- | --- | --- |
| White | British |  |
|  | Irish |  |
|  | Any Other White Background |  |
| Mixed | White and Asian |  |
|  | White and Black African |  |
|  | White and Black Caribbean |  |
|  | Any Other Asian Background |  |
| Asian or Asian British | Bangladeshi |  |
|  | Indian |  |
|  | Pakistani |  |
|  | Any Other Asian Background |  |
| Black or Black British | African |  |
|  | Caribbean |  |
|  | White and Asian |  |
|  | Any Other Black Background |  |
| Chinese or Other Ethnic Group | Chinese |  |
|  | Any Other Background |  |

For Official Use Only:

Accepted By: ……………………………………………………………………………………………………………………………………………………

Date Accepted: ………………………………………………………………………………………………………………………………………………..

Identification Type: ………………………………………………………………………………………………………………………………………….

Proof of Address Type: ……………………………………………………………………………………………………………………………………

Processed By: …………………………………………………………………………………………………………………………………………………..