Welcome to The Jolly Medical Centre.

To register with this practice please complete this questionnaire as fully as possible. The questions have been designed to help your new GP get to know you and your medical history. It may take some time for your previous medical records to reach us. The information you give will help us provide you with good medical care.

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| --- | --- | --- | --- | --- | --- |
| Personal Details | | | | | |
| Title |  | Have you been registered here before? | | | Yes No |
| Surname |  | Previous name |  | Male Female | |
| Forename(s) |  | Address |  | | |
| Date of birth |  |  |
| NHS number |  |  |
| Home Tel. No. |  | Postcode |  |  | |
| Mobile Tel. No. |  | Email |  | | |
| Work Tel. No. |  | Occupation |  | | |
| Next of kin |  | Relationship |  | | |
| Contact No |  | Address |  | | |
| Status | Single Married Separated Divorced Widowed Cohabitating | | | | |

**Consent given to contact for notification via🡪 1) Email  2) Mobile**

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| Health Details | | |
| Alcohol – alcohol use can affect your health and can interfere with certain medications and treatments.  You answers will remain confidential so please be honest.  Use the guide below to decide how many units you drink a week. | | |
|  | Do you drink any alcohol? | Yes  No |
| How many **units** week? |  |
| **Drugs** | |
| Do you have a drug addiction? | Yes  No |

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| --- | --- | --- | --- | --- | --- |
| Are you a smoker? | Yes No | How many a day? | |  | |
| Would you like support and/or information on giving up? | | | | | Yes No |
| Stopped smoking? | Yes No | When? |  | | |
| Never smoked? | Yes No |  | | | |

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| Medical history  Do you have, or have had, any serious health problems (including operations/ long term conditions? | | | | | |
|  |  | Details | | | Date (if known) |
| Asthma |  |  | | |  |
| Cancer |  |  | | |  |
| COPD |  |  | | |  |
| Chronic kidney disease |  |  | | |  |
| Diabetes |  |  | | |  |
| Epilepsy |  |  | | |  |
| Heart attack/disease |  |  | | |  |
| High blood pressure |  |  | | |  |
| High cholesterol |  |  | | |  |
| Osteoporosis |  |  | | |  |
| Stroke |  |  | | |  |
| Mental health problems |  |  | | |  |
| Underactive thyroid |  |  | | |  |
| Circulation problems |  |  | | |  |
| Other serious illnesses |  |  | | |  |
| Any operations |  |  | | |  |
|  |  |  | | |  |
| Any known allergies | Yes No | | Allergic to |  | |
| Details of reaction |  | | | | |

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| Repeat medication | | | |
| Are you on any repeat medication? | | | Yes No |
| If ‘yes’, do you have a repeat prescription slip from your previous GP? | | | Yes No |
| If ‘Yes’, please hand in at Reception. If ‘No’ then list below any current medication you are taking and make sure you show Reception all your medication in its original packaging and labelling. We may need to contact your previous GP surgery to confirm your medication. | | | |
| Name of drug | Frequency (how often drug is taken) | Reason for using drug | |
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| Family medical history  Have any of your immediate relatives (brothers/sisters/parents) had any of the following? | | | | | | | | | | |
|  | |  | Details | | | | Relationship | | Date (if known) | |
| Heart attack or angina before 60 | |  |  | | | |  | |  | |
| Heart attack or angina over 60 | |  |  | | | |  | |  | |
| Asthma | |  |  | | | |  | |  | |
| Diabetes | |  |  | | | |  | |  | |
| Stroke | |  |  | | | |  | |  | |
| Cancer | |  |  | | | |  | |  | |
| Any inherited diseases | |  |  | | | |  | |  | |
| Hospital Care ( the doctor may discuss with you the possibility of transferring you care to a local hospital) | | | | | | | | | | |
| Are you currently under hospital care? | | | | Yes No | | If ‘yes’ please complete details below | | | | |
| Hospital Name | | Name of Consultant | | | | Nature of problem | | | | |
|  | |  | | | |  | | | | |
|  | |  | | | |  | | | | |
| Do you consider yourself to have a disability? | | | | | | Yes No | | | | |
| Details of impairment | Physical impairment | | | |  | Learning disability/difficulty | | | |  |
|  | Sensory impairment | | | |  | Mental health condition | | | |  |
|  | Other (please state) | | | |  |  | | | | |
| Are you a carer? | Yes No | | | | Is someone a carer for you? | | | Yes No | | |

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| Females only | | | | | | | | |
| Date of last cervical smear? | |  | | Are your Pregnant? | | | Yes No | |
| Have you had a hysterectomy? | | Yes No | |  | | | | |
| Contraception – what is your current method of family planning? | | | | | | | | |
| None |  | | Coil | |  | Injection | |  |
| Contraceptive pill |  | | Sterilisation | |  | Implant | |  |
| Condom |  | | Partner had vasectomy | |  | Hysterectomy | |  |

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| Ethnicity – How would you describe your ethnicity? | | | | | | | | |
| White | British | Irish | | Other white | |  | |  |
| Asian | Asian British | Bangladeshi | | Indian | | Pakistani | | Other Asian |
| Black | Black British | African | | Caribbean | | Other black | |  |
| Mixed | Asian & White | Asian & Black | | Asian & Caribbean | | White African | | White Caribbean |
| Other | Chinese | Japanese | | Middle Eastern | | Turkish | | Any other Ethnicity |
| Please advise us on your first Language | | | English | | Other (please state) | |  | |

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| Children Only | | | | | |
| Please provide details of all vaccinations | | Date |  | | Date |
| Diphteria/Tetanus/ Whooping cough/ Polio | 1 |  | Meningitis C | 1 |  |
| 2 |  | 2 |  |
| 3 |  | 3 |  |
| Pneumococcal | 1 |  | Hib | 1 |  |
| 2 |  | 2 |  |
| 3 |  | 3 |  |
| Measles/ Mumps/ Rubella (MMR) | 1 |  | Hib booster | |  |
| 2 |  | Men C booster | |  |
| Preschool Diphteria/Tetanus/Whooping cough/Polio |  | | HPV | 1 |  |
| Rubella |  | | 2 |  |
| BCG |  | | 3 |  |
| Teenage booster Diphteria/Tetanus/Polio |  | | Other: | |  |
| Other: |  | | Other: | |  |

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| Appointments – please book the following appointments if applicable. | |
| If taking repeat medication | Appointment with GP required |
| If you have COPD/Asthma | Appointment with Nurse required |
| If you have Diabetes | Appointment with Nurse required |
| If you have heart disease or high blood pressure | Appointment with Nurse or Health care assistant required |
| If you want to quit smoking | Appointment with Nurse required |
| If you are under hospital care | Appointment with GP required |

**Application for online access to my medical record**

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name | |
| Address  Postcode | |
| Email address | |
| Telephone number | Mobile number |

I wish to have access to the following online services (please tick all that apply):

|  |  |
| --- | --- |
| 1. Booking appointments |  |
| 2. Requesting repeat prescriptions |  |
| 3. Accessing my medical record |  |

I wish to access my medical record online and understand and agree with each statement (tick)

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the practice |  |
| 2. I will be responsible for the security of the information that I see or download |  |
| 3. If I choose to share my information with anyone else, this is at my own risk |  |
| 4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement |  |
| 5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible |  |
| Signature  Date |  |

# For practice use only

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| Patient NHS number | | Practice computer ID number | | |
| Identity verified by (initials) | Date | Method  Vouching   Vouching with information in record   Photo ID and proof of residence  | | |
| Authorised by | | | | Date |
| Date account created | | | | |
| Date passphrase sent | | | | |
| Level of record access enabled  All  Prospective  Retrospective   Detailed  Limited parts  Contractual minimum  | | | Notes / explanation | |