Pinhoe & Broadclyst Medical Practice

Appointments/Enquiries - 01392 469668 / 469666

PERSONAL & FAMILY MEDICAL HISTORY

As there may be a delay in obtaining medical notes from your last Practice, this basic information will be of great help to your doctor. All the information given on this form will be treated as strictly confidential

.

When you return this form please provide some photo-ID and proof of your address.

Surname…… Title (please circle) Mr Ms Mrs Miss Other……

Forename(s)……

Maiden Name…… Date of Birth……

Telephone number…….Mobile……

Address…….....

…… ……..Post Code……..…..……

Email ……

Have you ever been registered at this Practice before ? ……

*The practice TXTs appointment confirmation/reminders. We may TXT general information, for example: notification of the annual Flu Vaccination programme to eligible patients. We will not TXT any information that is personal to you, without your consent.

If you do **NOT** want to receive any TXTs please tick this box ☐

ETHNIC CATEGORIES (circle one category only)

WHITE	MIXED	ASIAN OR BLACK BRITISH
British	White & Black Caribbean	Indian
Irish	White & Black African	Pakistan
Other	White and Asian	Bangladeshi
	Other mixed	Other Asian

BLACK OR BLACK BRITISH	CHINESE OR OTHER ETHNIC GROUP
Caribbean	Chinese
African	Any other
Any other Black background	ETHNICITY NOT STATED

Is English you first language? Yes/No (please circle)

If not, please state your first language……

Do you need an interpreter Yes/No (please circle)

DISABILITY Would you regard yourself as having any disabilities (please give details)

WOMEN ONLY

Are you fitted with an IUD or Coil? Yes/No (please circle)

Are you fitted with a contraceptive Implant Yes/No (please circle)

Are you taking oral contraceptives? Yes/No (please circle)

Have you ever had a cervical smear test? Yes/No (please circle)

Date of last test?.....

CURRENT OCCUPATION……

Please also list any previous occupations

……

……

FAMILY HISTORY				
Family Member	Alive		Deceased	
	Any Serious Illness *see list below	Age this illness started	Cause of Death	Age at Death
Father				
Mother				
Brothers				
Sisters				
Children				

* Alcoholism, Asthma, Black-outs, Cancer, Depression, Diabetes, Eczema, Glaucoma, Gout, Hay Fever, Heart Attack, High Blood Pressure, Migraine, Nerves, Stroke, Tuberculosis, Ulcer,

PERSONAL HISTORY Please list any serious illnesses, accidents or operations. Also include any X rays, scans or other investigations you have had.

Year	Illness/Accident/Operation/Investigation
……	……
……	……
……	……
……	……
……	……
……	……
……	……

MEDICATION

Do you take any regular medication or receive any other treatment? Please list below.
(If you have a Repeat Prescription re-order slip you can just attach that)

……

……

……

……

ELECTRONIC PRESCRIBING

We can send prescriptions electronically to any Chemist/Pharmacy that you choose. If you would like to use this service please tell us which Chemist/Pharmacy we should use:

…… .

STAFF USE ONLY- EPS Nomination Added ☐

You can change this in future if you wish, just let us know.

SMOKING (please tick)

I have never smoked ☐ I used to smoke - cigars/cigarettes/pipe ☐ Year I quit ……..
(please circle)

I smoke……. .Cigars ☐ Cigarettes ☐ Pipe ☐

Number smoked per day……or oz/grams per week……..

ALLERGIES - Do you have any allergies to food, drugs or other substances? Yes/No
(please circle)

Please give details……

……

ALCOHOL

How many units of alcohol do you drink per week……

One unit of alcohol = ½ pint of beer, a small glass of wine or a small measure of spirits

Please complete this short questionnaire

For the following questions please circle the answer which best applies.

Please note: 1 drink = 1/2 pint of beer or 1 glass of wine or 1 single spirit

1	MEN How often do you have EIGHT or more drinks on one occasion ? WOMEN How often do you have SIX or more drinks on one occasion ?				
Never (0)	Less than monthly (1)	Monthly (2)	Weekly (3)	Daily or almost Daily (4)	

2	How often during the last year have you been unable to remember what happened the night before because you had been drinking ?				
Never (0)	Less than monthly (1)	Monthly (2)	Weekly (3)	Daily or almost Daily (4)	

3	How often during the last year have you failed to do what was normally expected of you because of drinking ?				
Never (0)	Less than monthly (1)	Monthly (2)	Weekly (3)	Daily or almost Daily (4)	

4	In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down ?		
No (0)	Yes, on one occasion (2)	Yes, on more than one occasion (4)	

CARERS (1) Are you a Carer ? This means, do you provide unpaid care to a family member, partner or friend who needs help because they are ill, frail or have a disability.

If the person you care for is also a patient here, we can record this in their medical records. This will require their consent. If you want us to do this please give us the full name of the individual concerned

……

CARERS (2) Do you have a Carer ?

If Yes who ….……

If they are not registered at this practice, could we have their contact details?

……

……..

OTHER - Is there any other information that it would help your doctor to know about you ?

……

……

The NHS offer patients the choice of having a Summary Care Record.

The new NHS Summary Care Record has been introduced to help deliver better and safer care and give you more choice about who you share your healthcare information with.

WHAT IS THE NHS SUMMARY CARE RECORD?

The Summary Care Record contains basic information about:

- **any allergies you may have,**
- **unexpected reactions to medications, and**
- **any prescriptions you have recently received**.

The intention is to help clinicians in A & E Departments and 'Out of Hours' health services to give you safe, timely and effective treatment. Clinicians will only be allowed to access your record if they are authorised to do so and, even then, only if you give your express permission. You will be asked if healthcare staff can look at your Summary Care Record every time they need to, unless it is an emergency, for instance if you are unconscious. You can refuse if you think access is unnecessary.

Over time, health professionals treating you may add details about any health problems and summaries of your care. Every time further information is added to your record, you will be asked if you agree.

CHILDREN UNDER THE AGE OF 16

Patients under 16 years will not receive this form, but will have a Summary Care Record created for them unless their GP surgery is advised otherwise. **If you are the parent or guardian of a child then please either make this information available to them or decide and act on their behalf. Ask the surgery for additional forms if you want to opt them out.**

- If you are happy for a Summary Care Record to be set up for you then you need take no further action.
- If you want to opt-out now, please tick the box below, sign and return this form to Reception as soon as possible.

Please complete the details below if you <u>do not</u> want a Summary Care Record.

No, I do not want a Summary Care Record ☐

Full Name _____ Date of Birth ____/_____/_____

Signed _____ Date ____/_____/_____

For more information visit www.nhscarerecords.nhs.uk or call 0845 603 8510.

Information packs are also available at Reception.

For Practice Use Only

Actioned by Practice ☐ Read Code 93C3 added ☐

Date _____ Signed _____

Pinhoe & Broadclyst Medical Practice

APPLICATION FOR ACCESS TO MEDICAL RECORDS

The easiest way to access your medical records is by signing up to EMIS Patient Access.

If you would like to sign up, please fill out the Application Form below:

Surname:	DOB:
First Name:	
Address:	
Email Address: *	
Telephone Number:	Mobile Number:

*NB including your email address gives us consent to use it. See Patient Privacy Notice.

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 summary medical record	

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

I have read and understood the information leaflet provided by the Practice	
I will be responsible for the security of the information that I see or download	
If I choose to share my information with anyone else, this is at my own risk	
If I suspect that my account has been accessed by someone without my agreement I will contact the Practice as soon as possible	
If I see information in my record that is not about me or is inaccurate I will contact the Practice as soon as possible	
If I think that I may come under pressure to give access to someone else unwillingly I will contact the Practice as soon as possible	

Signature	**Date**

For Practice use only:

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 login details provided:		
Level of record access enabled: All Prospective Retrospective Detailed coded record Limited parts		Notes/explanation
Form to be scanned/attached to Patient Record		