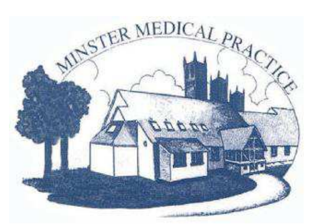



# MINSTER MEDICAL PRACTICE

Dr Jonathan Gibbs, Dr Christopher Batty, Dr Paul Fitzgerald, Dr Julia Brewin, Dr Sarah Culpitt
Practice Manager – Jo Downes
www.minstermedicalpractice.co.uk Tel: 01522 515797

## NEW PATIENT REGISTRATION FORM – OVER 16 YEARS

**Welcome to Minster Medical Practice. Please help the Doctors by completing this questionnaire as fully and accurately as possible.**

**PATIENT DETAILS** Date ___________________

| Mr Mrs Miss Ms Other | | Surname: | |
|---|---|---|---|
| Date of Birth: | / / | First Names: | |
| NHS No: | | Previous name/s: | |
| Home Address: | | | |
| Home Tel No: | | Mobile Tel No: | |
| **Preferred No:** | Home ☐ Mobile ☐ Other: | | |
| Email address: | | | |
| Marital status : | | Occupation: | |
| First language: | | Country of birth: | |
| Ethnicity: (please tick the most appropriate box) | British or Mixed British | Irish | |
| | Indian or British Indian | Chinese | |
| | Pakistani or British Pakistani | Caribbean | |
| | Bangladeshi or British Bangladeshi | African | |
| | White & Black Caribbean | Other Black background | |
| | White & Black African | Other White background | |
| | White & Asian | Other Asian Background | |
| | Ethnic category withheld | Other mixed background | |
| Height: | | Weight: | |

**NEXT OF KIN DETAILS**

| Name: | |
|---|---|
| Relationship to you: | |
| Contact Number: | |

**ARMED FORCES DETAILS**

| Have you ever serviced in the armed forces? | | YES / NO | |
|---|---|---|---|
| If YES are you still a reservist? | | YES / NO | |
| Enlistment date: | | Leaving date: | |

## FAMILY MEDICAL HISTORY

Have your parent(s) or sibling(s) suffered from any of the problems listed below – please circle the family member and write the age at which they were diagnosed:

| | | |
|---|---|---|
| Asthma | Father / Mother / Sister / Brother | Age: |
| Blood Pressure | Father / Mother / Sister / Brother | Age: |
| Cancer | Father / Mother / Sister / Brother | Age: |
| Diabetes | Father / Mother / Sister / Brother | Age: |
| Heart Attack | Father / Mother / Sister / Brother | Age: |
| Stroke | Father / Mother / Sister / Brother | Age: |

**MEDICAL HISTORY** - Please tick if you have a history of any of the following:

| | | | |
|---|---|---|---|
| Cancer | | Depression or Mental health problems | |
| Dementia or Alzheimers | | Kidney Disease | |
| Hypertension (high blood pressure) | | Heart Failure, Coronary Heart Disease or Atrial Fibrillation | |
| Asthma or COPD | | Learning Difficulties | |
| Diabetes | | Thyroid Disease | |
| Epilepsy | | Stroke or Transient Ischemic Attacks | |
| If you have any other history, important illnesses or disabilities not mentioned above please give details here (include special diet requirements): | | | |
| | | | |

## ALLERGIES

| | |
|---|---|
| Please list any allergies you have: | |

## MEDICATION

| |
|---|
| REPEAT MEDICATION: If you are currently taking any repeat medication, please list it below. You will need to book a review appointment with a GP to re-start your medication. Please make sure you have enough supply to last you for a month. |
| |

**PHARMACIES** – Please tick where you would like to collect your repeat prescriptions from:

| | | | |
|---|---|---|---|
| Co-op Cabourne | | Co-op Burton Road | |
| Co-op St. Botolphs (South Park) | | Co-op Winning post (Monks Rd) | |
| Boots High Street | | Boots Carlton Centre | |
| Tesco | | Watsons | |
| Lloyds | | Other | |
| Collect from Minster Medical Practice | | | |

**SMOKING STATUS** – Please tick boxes and complete as appropriate:

| | | | |
|---|---|---|---|
| Never Smoked | | N/A | |
| Ex – Smoker | | Date Stopped: | |
| Smoker | | How many per day? | |
| | | Would you like advice/help to stop smoking? | |

**ALCOHOL CONSUMPTION** – Please circle the most appropriate answer for all 3 questions:

| | | | | | |
|---|---|---|---|---|---|
| How often do you have a drink that contains alcohol? | Never | Monthly or less | 2-4 times per month | 2-3 times per week | 4+ times per week |
| How many standard drinks do you have on a typical day when you are drinking? | 1 – 2 | 3 – 4 | 5 – 6 | 7 – 8 | 10+ |
| How often do you have 6 or more standard drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |

**FEMALE PATIENTS** – if you use any form of contraception please circle which one:

| Coil | Depot Injection | Implant | Oral Pill | Other |
|---|---|---|---|---|

| | |
|---|---|
| If you do use contraception, when was your last check-up/review with GP or Nurse? | Date: |
| If you have a Coil or Implant, approximately what date was it fitted? | Date: |
| If you have depot injections when was your last one? | Date: |
| When was your last smear? | Date: |
| What was the result of your last smear? | Date: |

**PATIENTS AGED 65 AND OVER**

| | | |
|---|---|---|
| Have you had a flu vaccination in the last year? | Yes | No |
| If no, would you like one this year?<br>(Vaccines are in stock September to March each year) | Yes | No |
| Have you had a pneumonia vaccination? (only one required) | Yes | No |
| If no, would you like to be vaccinated? | Yes | No |

**PATIENTS AGED 70 AND OVER**

| | | |
|---|---|---|
| Have you ever had a shingles vaccination? | Yes | No |
| If no, would you like to be invited when you are eligible?<br>(Eligibility depends on age at the time of the vaccination) | Yes | No |

**HEALTH CHECKS -** Health checks are offered to all new patients not currently on any repeat medication. (Patients with repeat prescriptions will require an appointment with a GP when they are registered)

| Would you like to be offered an appointment with our Nurse for a health check? | | |
|---|---|---|
| New patient health check | Yes (we will contact you) | No |

**SMS/EMAIL CONSENT -** On occasion we may wish to contact you via text message or email, for example to send confirmation of appointment date and time or for health related messages.

| I **GIVE** consent for Minster Medical Practice to contact me via text message or email. | |
|---|---|
| Signature: | Date: |
| I **DO NOT GIVE** consent for Minster Medical Practice to contact me via text message or email. | |
| Signature: | Date: |

*Please remember to update the Practice if you change your telephone number or email address.*

**NHS PATIENT INFORMATION SHARING –** Please find enclosed leaflets for Summary Care Record and Electronic Patient Record Sharing IN and OUT. Please read these fully.

| I **CHOOSE** to have a NHS Summary Care Record | |
|---|---|
| Signature: | Date: |
| I **DO NOT CHOOSE** to have a NHS Summary Care Record | |
| Signature: | Date: |

| I **GIVE** consent for Minster Medical Practice to **SHARE IN** my electronic patient record | |
|---|---|
| Signature: | Date: |
| I **DO NOT GIVE** consent for Minster Medical Practice to **SHARE IN** my electronic patient record | |
| Signature: | Date: |

| I **GIVE** consent for Minster Medical Practice to **SHARE OUT** my electronic patient record | |
|---|---|
| Signature: | Date: |
| I **DO NOT GIVE** consent for Minster Medical Practice to **SHARE OUT** my electronic patient record | |
| Signature: | Date: |

**ADDITIONAL COMMUNICATION REQUIREMENTS –** Do you have any specific communication needs? By leaving this section blank we **will not** record alternative communication methods in your record. Please tick the boxes that apply.

| Braille Grade 1 | | Braille Grade 2 | |
|---|---|---|---|
| British Sign Language | | Contact via carer/third party | |
| Verbally (telephone) only | | Email only | |
| Text message only | | Large print font | |
| Interpreter | (please state language) | | |
| Other | (please state other) | | |

## CARERS QUESTIONNAIRE

**Who is a carer?** A carer is someone, who, without payment, provides help and support to a partner, child, relative, friend or neighbour, who could not manage without their help. This could be due to being elderly, physical or mental illness, addiction or disability.

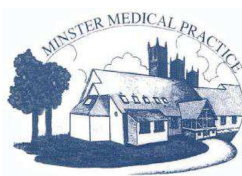
We would be grateful if you could complete the following questions for the practices Carer's Register. The register enables the practice to proactively manage carer's needs with the practice and to consider the provision of services to carers. The practice will also ensure that all patients who are carers are informed and supported in joining the local carer's link.

IF YOU ARE A CARER

| Details of the person(s) you are caring for | |
|---|---|
| Title | |
| Surname | |
| Forename | |
| Date of Birth | |
| Address | |
| Postcode | |
| Telephone number | |
| Relationship to patient | |

IF YOU ARE BEING CARED FOR

| Details of your carer | |
|---|---|
| Title | |
| Surname | |
| Forename | |
| Date of Birth | |
| Address | |
| Postcode | |
| Telephone number | |
| Relationship to carer | |




# Minster Medical Practice
# APPLICATION FOR INFORMATION TO BE SHARED WITH FAMILY MEMBER

**Details of the patient wanting information to be shared:**

| Patient Surname | NHS Number |
|---|---|
| Forename(s) | Address |
| Date of Birth | |

**Details of the Person information to be shared with:**

| Surname | |
|---|---|
| Forename(s) | |
| Address | |
| Telephone Number | |
| Relationship to Patient | |

Declaration: I would like the access below to be given to the person I have listed above. I accept that it is my responsibility to inform the practice if I want this access to be changed/ceased. I confirm that the practice will not be breaching my confidentiality by sharing this information with the person shown above and that the access will be in place until I inform the practice in writing of any changes.

Tick whichever of the following statements apply:

- ☐ I would like the above person to be able to access information about my appointment details, ie book appointments, confirm dates/times
- ☐ I would like the above person to be able to request medication on my behalf
- ☐ I would like the above person to be given information about my medication
- ☐ I would like the above person to be given my test results
- ☐ I would like any information about my healthcare contained in my medical records to be shared with the above person

**Applicant signature.................................................Date……………………….**

## Patient checklist for completing the registration form:

NHS Number (can be obtained from previous GP Practice) ☐

Contact details (address, telephone number and email) ☐

Previous GP details ☐

Proof of address ☐

Photo ID ☐

Return forms to the Practice with proof of address and ID ☐

## Practice checklist when form returned by patient:

Photo ID ☐

Proof of Address ☐

Address within our catchment area ☐

Telephone numbers ☐

NHS Number ☐

Town and Country of birth ☐

Previous GP ☐

Full previous address ☐

SMS consent ☐

Summary Care Record consent ☐

Sharing in and out preferences ☐

New patient health check ☐

Smoking and alcohol status ☐

Checked by …………………………………………. Date……………………..