

Heacham Group Practice
45 Station Road, Heacham Kings Lynn PE31 7EX
Tel: 01485 572769
www.heachamgrouppractice.nhs.uk
New Patient Registration Questionnaire (Age 16+)

Office Use Only:
Registered GP:
Checked by:

Patient check list (tick below)	
Photographic identification (photo driving license card or passport)	
Your NHS number which you can obtain from your previous doctors surgery	
If you are taking regular medication please ensure you obtain 1 month's medication from your previous surgery to allow us time to add your medication to your notes. You <u>must</u> also bring a copy of your repeat prescription with this form.	
Any vaccination records you may have	
Proof of Address (copy of recent utility bill)	

Title*	Mr <input type="checkbox"/>	Mrs <input type="checkbox"/>	Miss <input type="checkbox"/>	Ms <input type="checkbox"/>	Other – <i>please specify</i>
Full name :*					
Date of birth:	DD/MM/YYYY	Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Other – <i>please specify</i>
Address: *					
Post code:*					
Preferred Mobile telephone number: We will use this number to send appointment reminders & information texts to your mobile phone. Please tick here if you give your consent for this. <input type="checkbox"/> Yes					
Preferred Home phone number :					
Email Address:					
<u>IF APPLICABLE</u> – CARE HOME REGISTRATIONS*			Next of Kin name: *		
Is this address for-			Contact details: *		

Residential Care? Yes <input type="checkbox"/> No <input type="checkbox"/>				
Nursing Care? Yes <input type="checkbox"/> No <input type="checkbox"/>		Relationship to you:*		
Have you ever served in the British Armed Forces ?				
Army	Military	Royal Air force	Royal Marines	Royal Navy

Information about you and your medical history

Please record your blood pressure, pulse, height and weight					
Height*		Weight *		Blood pressure* Pulse *	
Please tell us about the type of work you do:*					
Country of Birth:*			Main language spoken:*		Interpreter required. Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have any allergies? Yes <input type="checkbox"/> No <input type="checkbox"/> *			If yes what are your allergies?		
Do you take regular exercise? E.g. 20min brisk walking, 1/2/3 times per week?* Yes <input type="checkbox"/> No <input type="checkbox"/>			If no why is that ?		
Do you smoke? * Yes <input type="checkbox"/> No <input type="checkbox"/> Ex-Smoker <input type="checkbox"/> If yes how many per day -			Please note if you want to stop smoking you can find useful information at: www.smokefreenorfolk.nhs.uk		
<u>*Alcohol consumption – please complete below:</u>					
Q1. How often do you have a drink containing alcohol?		Q2. How many units of alcohol do you drink on a typical day when you are drinking?		Q3. How often do you have 6 or more units (if female) or 8 or more units (if male) on a single occasion?	
Never		1or 2		Never	
Monthly or less		3 or 4		Less than monthly	
2-4 times a month		5 or 6		Monthly	
2-3 times a week		7 or 8		Weekly	
4 or more times a week		10 or more		Daily or almost daily	

***Female patients only**

All ladies between the age of 25 and 65 are routinely offered a cervical screening (smear test pap smear) every 3-5 years. Please answer the questions below.

*What was the date of your last cervical screening? :

*If you are due for your cervical screening would you like to book an appointment? Yes ☐ No ☐ if yes a member of our team will contact you

Are you a carer? Yes ☐ No ☐

If yes, we would like to be able to support you and highlight that you are a recognised carer

Please tell us who you are for and your relationship to them?

Name: Relationship to you?

Ease of access due to disability/impairment/sensory loss

Please tick if you have any of the following:

Sight impairment <input type="checkbox"/>	Hearing impairment <input type="checkbox"/>	Disability <input type="checkbox"/>	Other* <input type="checkbox"/>
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Please select your preferred method of contact:

Letter <input type="checkbox"/>	E-mail <input type="checkbox"/>	Telephone Call <input type="checkbox"/>	SMS Message <input type="checkbox"/>
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Other* - Please state:

All of this information will remain completely confidential and will not be used for any other purpose

Please indicate the Ethnic group to which you feel you belong:*

White

- ☐ British
- ☐ Irish
- ☐ Any white background

Mixed

- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian
- ☐ Any other mixed background

Asian or Asian British

- ☐ Indian

- ☐ Chinese
- ☐ Any other Asian background

Black or Black British

- ☐ Caribbean
- ☐ African
- ☐ Any other black background

Other Ethnic Groups

- ☐ Arab
- ☐ Any other ethnic group

- ☐ Pakistani
- ☐ Bangladeshi

Sharing of information and your health record

Information about your health and care help the NHS to improve your individual care, speed up diagnosis, plan your local services and research new treatments.

*Share out- Will you consent to share your medical record with any other health care provider involved in your care ☐ Yes ☐ No

*Share in- Will you consent to Heacham Group Practice viewing information in your medical record recorded by other health care services? ☐ Yes ☐ No

Summary Care Record – your emergency care summary

The NHS in England introduced the Summary Care Record to be used in emergency care.

The record will contain information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had to ensure those caring for you to have enough information to treat you safely.

Your Summary Care Record will be available to authorised healthcare staff providing your care anywhere in England, but they will ask your permission before they look at it. This means that if you have an accident or become ill, healthcare staff treating you will have immediate access to important information about your health.

As a patient you have a choice:

*Yes I would like a Summary Care Record – You do not need to do anything and a summary care record will be created for you.

*No I do not want a Summary Care Record – Please ask reception for a **Summary Care Opt Out form**, complete it and return to the surgery.

Online access

All patients are offered an online account.

I would like an online account.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Please request an online access form from reception and an account will be generated for you

Do you use the NHS app to access your medical records	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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