QUEENSWAY SURGERY

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CONFIDENTIAL DOCUMENT
Please note that any information supplied will not affect your registration at this surgery, it is important to know so that we can ensure correct information is stored on your medical record.

How do you prefer to be addressed: e.g. Dr/Mr/Mrs/Ms/Miss, etc.………………………….

Forename**:** ……………………………………….. Surname**:** …………………………………………

Date of Birth**:** ……………............................... NHS No. (if known)……………………………..

Home Tel**:** ……………………………………… Mobile Tel**:** ………………………………………

Please circle your preference: *I do/don't accept SMS messages from Queensway Surgery*

Email Address**:** ………………………………………………………………

Queensway surgery offers safe and secure Online Access to the following services by default to all newly registered patients:

- Booking and cancelling appointments
- Viewing and Ordering Repeat Medication

By supplying your email address, we assume you would like an online account to be able to access these services from home – if you would **not** like to have an online account please tick this box ☐

Local Chemist/Pharmacy name: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
Queensway surgery will send any prescriptions for you directly to the pharmacy/chemist you name above.

Allergies:

Current Medication _

_ _

_ _

_ _

_ _

Please continue on reverse if required. Please include any non-prescription and over the counter that you regularly use.

Do you smoke tobacco? YES / NO / NEVER If yes how many each day? …………….

Have you given up? If so, when?........................... would you like help to give up YES/NO

Alcohol intake (please complete table below)

Questions		Scoring System				Your Score
	0	1	2	3	4	
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 alcoholic drinks do you have on a typical day when you are drinking?	1 – 2	3 - 4	5 - 6	7 - 9	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Family History *family includes: your grandparents ,parents & siblings.* (please circle all that apply)

High Blood Pressure	Diabetes	Cancer
Mental Illness	Lung Disease inc. asthma	Heart Disease / Stroke

YOUR PERSONAL MEDICAL HISTORY

Listed below are some diseases/conditions. You will see each has a "current" box, and some also have a "past" box. Please tick the box/es that apply to you e.g., if you had Asthma as a child but don't have Asthma anymore, then you would tick the "past" box; another example, if you have cataracts and are having or waiting for treatment, then you would tick the "current" box.

Disease/Condition	Current (Onset date if known)	Past
Angina		
Heart Attack		
Coronary Heart Disease		
Heart Failure		
Stroke/TIA		
Hypertension		
Pacemaker		
Atrial fibrillation		
Peripheral arterial disease		
Asthma		
COPD		
Diabetes Type 1		
Diabetes Type 2		
Epilepsy		
Cancer (please could you give details)		
Mental Health – please specify		
Depression		
Dementia		
Chronic Kidney Disease(CKD) Stage 1 / 2 / 3 or 4		
Continued from Previous page	**Current**	**Past**
Learning Difficulties e.g ADHD, Dyslexia		
Learning Disability – mild, moderate, severe		
Osteoporosis(have you had a bone density scan in the last 3 years?)		
Rheumatoid Arthritis		

Fibromyalgia		
Chronic Fatigue (ME)		
Multiple Sclerosis		
Eye disease – please specify		
Gastrointestinal disease		
Coeliac Disease		
Sexually Transmitted Disease (please specify eg Chlamydia)		
Are you sexually active?		
Would you like an HIV blood Test?		
Hyperthyroid/overactive thyroid		
Hypothyroid/underactive thyroid		
Other – please specify		

Are you a carer for a relative, friend or neighbour? (Please circle) **YES/NO**

Is there a relative, friend or neighbour who helps to look after you? (Please circle) **YES/NO**

Please give details **Name:**_____________________ **Contact No:** _____________________

Next of Kin (Mr / Mrs / Ms / Miss/) (please circle)_ _

Tel: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _**Relationship to patient** _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Details of any family members registered at the Practice (e.g. mum/dad/brother/sister/child)

Name: _ **Date of Birth:** _ _ _ _ _ _ _ _ _ _ _

Relationship:

Name: _ **Date of Birth:** _ _ _ _ _ _ _ _ _ _ _

Relationship:

Name: _ **Date of Birth:** _ _ _ _ _ _ _ _ _ _ _

Relationship:

Name: _ **Date of Birth:** _ _ _ _ _ _ _ _ _ _ _

Relationship:

Name: _ **Date of Birth:** _ _ _ _ _ _ _ _ _ _ _

This is so that we can update your Groups and Relationships page – members of the same Family and can be quickly located and identified.

Summary Care Record

If you are registered with a GP practice in England, you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. You may need to be treated by health and care professionals who do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs.

Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you. Having read the above information regarding your choices, please choose **one** of the options below and return the completed form to your GP practice:

Yes - I am happy for my Summary Care Record to be shared out.

□ Express consent for medication, allergies, adverse reactions and information relevant for my care.

--or --

No – I DO NOT give consent to a shared Summary Care Record

□ Express dissent for Summary Care Record (opt out).

Name of patient: …….. NHS No: ……

Date of birth: …… Patient's postcode: ……

Queensway Surgery **Southend on Sea**

Surgery name: …… Surgery location (Town): ……..

Signature: …….. Date: ……

If you are filling out this form on behalf of another person, please ensure that you fill out their details above; you sign the form above and provide your details below:

Name: ……..

Please circle one: Parent

Legal Guardian

Lasting power of Attorney for Health & Welfare