College Health Ltd

NEW PATIENT QUESTIONAIRE – OVER 18 YEARS

Welcome to College Health Ltd. The following information you give will help us to provide better care for you. You will need to provide two proofs of ID. Acceptable forms of ID are:

1. Passport or driving licence
2. A recent utility bill

Once you have completed this form, please return to reception along with your ID.

Mr/Mrs/Miss/Ms/Other: _____ Date of Birth: _____

Surname: _____

Forenames: _____

Address: _____

Postcode: _____

Home Tel: _____ Mobile: _____

Work Tel: _____ Email: _____

Occupation: _____ Town & Country of Birth: _____

Consent for SMS of appointments/important Updates? Yes □ No □

Consent for email? Yes □ No □

System Online? Yes □ No □

Are you a carer? Do you provide care for someone (a relative, friend, neighbour) on a regular basis? Yes □ No □

If so, who do you care for? _____

Next of Kin Details:

Name: _____ Relationship to you: _____

Address: _____

Phone: _____

Is there anyone else living at your Address?

Name: _____ Relationship to you: _____

Name: _____ Relationship to you: _____

Name: _____ Relationship to you: _____

Name: _____ Relationship to you: _____

Medical Conditions/Operations:

Please state below dates and treatment:

Repeat Medication:

If possible please attach prescription repeat sheet.

Drug Name	Strength	Frequency

Personal Medical History:

Condition	Yes/No	Condition	Yes/No
Asthma		Epilepsy	
Blood Pressure (High/Low)		Heart Problems (angina, heart attack)	
Cancer		Thyroid Problem	
COPD (chronic bronchitis/ Emphysema)		Stroke TIA (transient ischaemic attack)	
Diabetes			

For Women only:

Do you use contraception? Yes/No	If Yes, What Kind?
When was your last smear?	Where was this done?

Allergies	For women over 50
Are you allergic to any medication? Yes □ No □ If Yes, please give details:	Have you ever had breast screening? Yes □ No □ If yes, when was this done?

Significant Family History:

Has anyone in your family had high blood pressure? Yes □ No □	Has anyone in your family had a stroke? Yes □ No □ Age at Diagnosis:
If yes, please provide details of who: Mother Father Sister Brother	If Yes, please provide details of who: Mother Father Sister Brother
Has anyone in your family had a heart attack or angina? Yes □ No □	Have members of your family suffered from any other health problems? Yes □ No □
If Yes, Please provide details of who: Mother Father Sister Brother	If yes, Please give details:
Was your relative over or under 60 when they first had their symptoms? Over 60 □ Under 60 □	

Immunisations:

When did you last have a Tetanus Injection? _____

Please list below any recet Immunisations given in the last year:	Date Given
Have you had a Flu Vaccination? Yes □ No □	Date Given
Have you had a Pneumococcal Vaccination? Yes □ No □	Date Given

Ethnic Origin:

The Department of Health has asked us to record the ethnic origin of all new patients. This information will be added to your medical records. If you do not wish to provide this information, then please tick the refusal box at the end of the list.

White - British		Asian or Asian British – Indian	
White – Irish		Asian or Asian British – Pakistani	
Other white background		Asian or Asian British – Bangladeshi	
Mixed – white and black Caribbean		Other Asian background	
Mixed – White and black African		Black or Black British – Caribbean	
Mixed – White and Asian		Black or Black British – African	
Other mixed background		Other Black background	
Chinese		Other Ethnic background	
Information refused			

What is your first or main language that you speak? _____
Do you ever need an Interpreter? Yes □ No □

Disability:
Do you have any disability needs? Yes □ No □
Do you have a carer? Yes □ No □
Please provide Carers details:
Name: _____
Address: _____
Contact number: _____

Email and SMS:
We would like to keep you informed of appointments and other relevant information. Do you consent to contacting you?

Yes – Text □ No – Do not text □
Yes – Email □ No – Do not Email □

Lifestyle:
What exercise do you do on a regular basis? _____
How often? _____
What is your weight? _____ What is your height: _____

Smoking:
Do you smoke?

Yes □ How many per day? _____	No □
If yes would you like help to stop smoking? We can arrange for you to be booked into our smoking cessation clinic. Yes □ No □	Have you ever smoked? Yes □ No □ When did you stop? _____ How many per day? _____

Alcohol:

Please circle appropriate answer:	Scoring system				
	0	1	2	3	4
How often do you have a drink containing alcohol?	Never	Monthly Or less	2 – 4 times per month	2 – 3 times per week	4+ times per week
How many units of alcohol do you drink on a typical day when you are drinking?	1 – 2	3 – 4	5 – 6	7 – 9	10+
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

Please continue to circle appropriate answers:

Questions	0	1	2	3	4
How often during the last year have you found that you were not able to stop drinking once you have started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you failed to do what was normally expected from you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Have you or someone else been injured as a result of your drinking?	No		Yes but not in the last year		Yes during the last year
Has a relative, friend, Doctor or health worker been concerned about your drinking or suggested that you cut down?	No		Yes but not in the last year		Yes during the last year
Do you consider that you have or ever had an alcohol problem?	No		Yes but not in the last year		Yes during the last year

Consent:

An informed patient, in consultation with Health Care Professional, can choose or restrict access to the information entered into their record at each SystmOne organisation that accesses their record. The patient will be asked to give their sharing consent at each organisation at which they receive care. The patients consent can be changed at any time.

Sharing out

Do you consent to the sharing of data recorded here with any organisations that may care for you? (Opting out may result in difficulty when other care not provided by College Health Ltd is needed).

Opt - in □
Opt – out □

Sharing in

Do you consent to the viewing of data by this organisation that is recorded at other services that may care for you where you have agreed to make the data sharable?

Consent given □
Consent refused □

Signed: _____ Date: _____

SYSTMONLINE APPLICATION FORM

Surname	
First name	
Date of birth Address	
Postcode	
Email address	
Telephone/mobile number	

I would like to register for the following services:

1. Booking appointments	□
2. Requesting repeat prescriptions	□
3. Accessing my medical records	□
4. Accessing my test results	□

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

1. I have read and understood the information leaflet provided by the practice on the reverse of this form	□
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 log out immediately and contact the practice as soon as possible	□
6. I consent to receiving emails from the practice regarding my health care (only tick if your email address is secure and you check your emails regularly)	□
7. I would like to sign up to receive the practice newsletter by email	□

Signed: _____ Date: _____

Patient Online: Records Access – Patient Information Leaflet ' It's Your Choice'

If you wish to, you can now use the internet to book appointments with a GP, request repeat prescriptions for any medications you take regularly and look at your medical records online. You can still use the telephone or call into the surgery for any of these services as well. It's your choice.

That you are able to see your record online might help you manage your medical conditions. It also means that you can even access it from anywhere in the world should you require medical treatment on holiday. If you decide not to join or wish to withdraw, this is your choice and practice staff will continue to treat you in the same way as before. In general this decision will not affect the quality of your care.

You will be given log in details, so you will need to think of a password that is unique to you. This will ensure that only you are able to access your record – unless you choose to share your details with a family member or carer.

The practice has the right to remove online access to services for anyone that doesn't use them responsibly.

It will be your responsibility to keep your login details and password safe and secure. If you know or suspect that your record has been accessed by someone that you have not agreed should see it, then you should change your password immediately. If you can't do this for some reason, we recommend that you contact the practice so that they can remove online access until you are able to reset your password.

If you print out any information from your record, it is also your responsibility to keep this secure. If you are at all worried about keeping printed copies safe, we recommend that you do not make copies at all.

Before you apply for online access to your record, there are some other things to consider: Although the chances of any of these things happening are very small, you will be asked that you have read and understood the following before you are given login details:

● Forgotten history – There maybe something you have forgotten about in your record that you may find upsetting.

● Abnormal results or bad news – If your GP has given you access to test results or letters, you may see something that you find upsetting to you. This may occur before you have spoken to your Doctor or while the surgery is closed and you cannot contact them.

● Choosing to share your information with someone – it's up to you whether or not you share your information with others – perhaps family members or carers. **It's your choice, but also your responsibility to keep the information safe and secure.**

● Coercion – If you think you may be pressured into revealing details from your patient record to someone else against you will, it is best that you do not register for access at this time.

●Misunderstood information – Your medical record is designed to be used by clinical professionals to ensure that you receive the best possible care. Some of the information within your medical record maybe highly technical, written by specialists and not easily understood. If you require further clarification, please contact the surgery for a clearer explanation.

● Information about someone else – If you spot something in the record that is not about you or notice any errors, please log out of the system immediately and contact the practice as soon as possible.

More information

For more information about keeping your healthcare records safe and secure, you will find a helpful leaflet produced by the NHS in conjunction with the British Computer Society:

'Keeping your online health and social care records safe and secure'. 2 v1 23 September 2014.

Website:https://systmonline.tpp-uk.com

FOR OFFICIAL USE ONLY

Photo ID scanned - Yes □ No □

Proof of Address Scanned/copied Yes □ No □

Form Checked and fully completed Yes □ No □

Receptionist Name: _____

Date: _____