Welcome to Ferry Road Health Centre

Please take the time to fill in this questionnaire as fully as possible (print clearly)

About You

Forename/s		Title (Mr/Mrs/etc)	
Surname		Date of Birth	
Mobile Telephone		Your First Language	
Email Address		Your Ethnicity	
Consent *(tick all that apply)*	contact by phone / mobile □ contact by email □	Marital Status	Single □ Married □ Widowed □ Co-Habiting □
Ex-armed forces	Army / Navy / Airforce From ……. to…….	Occupation (If retired previous occupation)	

Do you have any communication needs? No ☐ Yes ☐ If yes, Do you have support, i.e. advocate/note taker/sign language □ Do you need specific format, i.e. large print, easyread, braille □
Mobility Fully mobile ☐ Mobile with aid ☐ Housebound ☐
Are you currently involved/working with any other services (e.g. Adult Social Care/Social Services/Health Visitors). Please give any information you feel may help us with your care.

Next of Kin		**Other Contact in Emergency**	
Full Name		Full Name	
Address		Address	
Relationship to you		Relationship to you	
Contact No.		Contact No.	

Carer Details

Are you a Carer? Yes * □ No □ Do you have a Carer? Yes * □ No □ (*details below if you have their permission to give us their name)	
Who do you care for?	
Who are you cared for by?	

Registration Documentation – We have to see one of the following documents from Parts 1 & 2 before we can accept you as a patient	
1. Proof of Identity - *Please circle which one you are providing*	
UK Nationals	Photo Driving Licence, Birth Certificate, Marriage Certificate, Medical Card, Passport, N.I. Number, Photo Card, Evidence of Benefit entitlement
European Economic Area	Passport, European Health Card (EHIC not E111)
Non UK Nationals	Visa, Residence Permit, Work Permit, Student Visa or letter from educational establishment
Date Entered Country	
2. Proof of Address – *Please circle which one you are providing*	
	Local Authority Rent Card, Paid Utility Bill (Gas/Electric/Phone including mobile), Bank Statement, Council Tax Documents

Health Questionnaire **Name:** **DOB:**

You will be registered with Dr ……..…… (This will be your "Named GP")

Answer as fully as possible if data known; if you need anything explained please do ask.

Smoking Status	Never Smoked □ Ex- (when did you stop) □ When did you stop Current Smoker □ How many cigarettes per day on average If you are a smoker would you like information on stopping smoking □
Alcohol	If you drink – how much per week
Diet	Are you on any special diet (i.e. weight loss, gluten free, vegan)

Do **YOU** suffer from/ have you suffered from any of the following:	If yes when	Do **YOU** suffer from/ have you suffered from any of the following:	If yes when
Heart Attack		Liver disease or splenectomy	
Angina		Kidney Disease	
High Blood Pressure		Chronic lung Disease	
Coronary Artery Operations		Asthma	
Stroke/ CVA/ TIA		Osteoporosis	
DVT or pulmonary embolism		Psychiatric or Emotional Problem	
Thyroid Disease		Other Operations or Accidents	
Diabetes – controlled by diet □ Diabetes – controlled by insulin □ Diabetes – controlled by tablets □		Cancer - Please give details	
Do you have any drug /non-drug allergies?		Do you suffer from any other medical condition?	

Has any **family** member had / developed	If yes - Who	Cancer – (especially of breast, ovary or bowel)	
Heart disease before the age of 60			
Heart disease later than 60		Been diabetic	
Had strokes		Had or got asthma	

Cervical Smear Record (Women over 16 only)			
When do you think your last smear was		Do you use any form of contraception	Yes / No
Have you had a hysterectomy?		If yes – which one	
How many children have you had?		If a coil when was it fitted?	

Repeat Medications Please attach a copy of your repeat prescription for medication prescribed to you.

If you live in Rye which Chemist would you like to use

Boots ☐ Day Lewis ☐ Jempsons (Peasmarsh) ☐

If you live outside of Rye we will dispense your medication

Your Summary Care Record – Permission to share your medical information with other healthcare professionals

For each patient a Summary Care Record (SCR) can be created to allow healthcare agencies (i.e. hospitals, ambulance service and out of hour's providers – with appropriate permissions) to access information held by this practice and includes important information about your health:

□ **Medicines you take** □ **Allergies you have** □ **Medicines that make you ill**

Doctors and nurses can look at it to help them treat you safely and quickly. You might need to see a doctor or nurse who does not know you. If they do not know about your care, your SCR could:

□ Stop them making a mistake because they can see your medicines, allergies or what medicines make you ill

□ Help them see your information straight away because it is stored on computers

You can choose

You can choose to have other useful information added to your SCR, including:

□ Your illnesses and any health problems

□ Operations and vaccinations you have had in the past

□ How you would like to be treated

□ What support you might need

□ Who to contact for more information about you

What to do next

Please complete **one** of the four option boxes below - For more information, please visit https://www.digital.nhs.uk/summary-care-records/patients, call NHS Digital on 0300 303 5678

Tick ONE	**Summary Care Record consent preference**	Code (for surgery use)
	The patient wants a Summary Care Record with core and additional information (express consent for medication, allergies, adverse reactions and additional information)	9Ndn/ XaXbY
	The patient wants a core Summary Care Record (express consent for medication, allergies and adverse reactions only)	9Ndm/ XaXbZ
	The patient does not want to have a Summary Care Record (express dissent for Summary Care Record – opt out)	9Ndo/ XaXj6
	The patient wishes to opt out of NHS Digital Data Sharing of confidential information for research or planning purposes PATIENTS have to register for this personally by visiting the website www.nhs.uk/your-nhs-data-matters (providing the surgery has an up to date mobile or email address for the patient on record) or PATIENT has to ring 0300 3035678 to register	Not coded locally

Patient's full name:…… Date of Birth……

Patient's 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

*You can change your mind at any time by informing the GP surgery of your decision