Your registered GP will be: Dr S Barnes

Park Practice
Eastbourne

New Patient Questionnaire (under 16)

Title: (Mr/Mrs/Miss/Ms/Mx/Other) ________________ Male: ☐ Female: ☐

Is your gender the same as the one you were assigned at birth: Yes: ☐ No: ☐

Name: ___________________________ Date of birth: ________________________

Telephone number (House): _______________

(Mobile – please advise whose mobile number this is: PARENT / CHILD): ________

By supplying this mobile telephone number, you consent to us contacting you via text for reminders and your care at the practice. To opt out of this service please tick here: ______

Address: ____

Email address (please supply your child's email address here if they have one and you are happy to share it): ____

Today's Date: ____________________

1. Name of next of kin: ____________________________

   Contact No: ____________________________

   Relationship: ____________________________

2. Name of next of kin: ____________________________

   Contact No: ____________________________

   Relationship: ____________________________

In order to obtain your medical records in a timely fashion, please tick here if you are not presently registered with any practice due to them off listing you for moving out of the practice area. ☐

Contacting you

Your registered GP will be: Dr S Barnes
We may need to contact you by post, telephone, text or email for direct medical care. We may leave a message on your answer phone for you to contact us. If you have any objections to the above please inform the practice in writing.

To comply with GDPR (General Data Protection Regulations) we need your specific consent to contact you for the following:

Text (SMS)

Are you happy for us to contact you for appointment reminders and other medical related information via text message?

Yes ☐ **No** ☐ **I do not have a mobile phone** ☐

Emails

Are you happy for us to contact you with surgery information via email?

Yes ☐ **No** ☐ **I do not have an email account** ☐

Please note that you can opt in or out of either of these services at any time by contacting a member of the reception team, emailing us or by using the text message opt out option.

Important information about our surgery and ways we may contact you can be found on our website under 'GDPR': www.parkpractice.co.uk and in our waiting room.

We would like to inform our patients that we record, store, and may monitor or use any incoming and outgoing calls, email or any other communication with you for training purposes and to improve the quality of our services. Calls are stored on a standalone recording system and are not accessed unless there is a training or monitoring need. Calls are automatically deleted after 6 months. Should you wish a telephone call to be deleted before the 6 month period, please contact the practice to request this from a member of the management team.

Do you have any special communication needs? ☐ Yes ☐ No

If yes, please let us know how we can help you.

____

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Main language taught if <u>NOT</u> English:__________________________________

Ethnic Category Code (Please tick)

White		
• English/Welsh/Scottish/Northern Irish/British	☐	976631000000101
• Irish	☐	976651000000108
• Gypsy or Irish Traveller	☐	976671000000104
• Any other White background	☐	976691000000100
Mixed/Multiple ethnic groups		
• White and Black Caribbean	☐	976711000000103
• White and Black African	☐	976731000000106
• White and Asian	☐	976751000000104
• Any other Mixed/Multiple ethnic background	☐	976771000000108
Asian/Asian British		
• Indian	☐	976791000000107
• Pakistani	☐	976811000000108
• Bangladeshi	☐	976831000000100
• Chinese	☐	976851000000107
• Any other Asian background	☐	976871000000103
Black/African/Caribbean/Black British		
• African	☐	976891000000104
• Caribbean	☐	976911000000101
• Any other Black/African/Caribbean background	☐	976931000000109
Other Ethnic Groups		
• Arab	☐	976951000000102
• Any other ethnic group	☐	976971000000106
Not stated - I do not wish to state	☐	92531000000104

<u>Summary Care Record</u>

SUMMARY CARE RECORD (SCR)
The Summary Care Record is a copy of key information from your GP record. The Summary Care Record provides authorised care professionals working elsewhere in the NHS with faster, secure access to essential information about you when you need care. All patients will have a **core Summary Care Record** unless they have previously informed their GP practice that they didn't want one. A **core Summary Care Record** includes details of the medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had in the past. We would now like to offer you the opportunity to allow **additional information** to be added to your Summary Care Record including significant medical history, illness

and operations (past and present), reasons for medications, and care plan information (if any).	
If you would like to have an SCR with Additional Information please tick here.	
If you no longer wish to have a core or additional SCR, please ask at reception for an opt-out form.	

Past Illnesses

Please list any serious illnesses/operations/accidents etc.

YEAR	ILLNESS ETC

Family History – serious illness and death only

	Age of diagnosis if known.	Serious illness, heart, diabetes, stroke, cancer, etc	Age at death	Cause of death if known
FATHER				
MOTHER				
BROTHER				

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SISTER				

Medication

Are you on any repeat medication: Yes ☐ No ☐ (please move to Allergies)

If yes, we use an electronic prescribing service (EPS) and this enables us to send your prescription electronically to a chemist of your choice.

Please state the name and street name of your nominated pharmacy

Name:……………………………………………………Street:..……………………………

……………………………………….. and sign here: ________________________

You may be asked to book an appointment with your doctor for your first prescription. Please allow plenty of time before your medication runs out.

Allergies

If you have had any allergies to drugs, food or injections please list them and what happened..……………………………………………………………………………………
…………………………………………………………………………………………………
…………………………………………………………………………………………………

If you are aged 14 year or over, please complete the following:

Smoking

1. Do You Smoke: Yes No ☐ (**If no see Question 2**)
   If yes do you **S**moke: **C**igarettes ☐ Ci**g**ar's ☐ **P**ipe ☐ **R**oll-ups ☐
   How many ounces or cigarettes a day? _______________
   How many years have you smoked for? _______________
   If you would like help giving up, please see the leaflet on the back page.

2. Are you an **E**x-smoker: Yes ☐ No ☐ **(If no see Question 3)**
   If yes how many years did you smoke for? ________ How long ago did you stop?
   What did you smoke: **C**igarettes ☐ **C**igars ☐ **P**ipe ☐ **R**oll-ups ☐
   How many ounces or cigarettes a day _____

3. Are you a **P**assive smoker Yes ☐ No ☐ (**if no see Question 4)**

4. Are you a lifelong non-smoker? Yes ☐ No ☐