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| ***YOUR DETAILS*** |
| First Name(s) |  | Surname |  |
| Title |  | Date of Birth |  |
| Address | House Name/Flat Number |  |
| Number and Street |  |
| Locality and Town |  |
| County |  |
| Postcode |  |
| Email Address |  |
| Home Tel. No. |  | Mobile Tel. No. |  |
| The surgery has a text message & email service to remind you of upcoming appointments. If you would like to **OPT OUT** of this service, please let us know. |
| Gender |  | Marital Status |  |
| Ethnic Origin |  | First Language |  |
| Do you have a disability? i.e. sight or hearing impairment | **YES** [ ]  | **NO** [ ]  |
| If Yes, do you have any information or communication needs on how we should contact you? |  |

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| ***NEXT OF KIN*** |
| First Name(s) |  | Surname |  |
| Relationship |  |
| Address | House Name/Flat Number |  |
| Number and Street |  |
| Locality and Town |  |
| County |  |
| Postcode |  |
| Home Tel. No. |  | Mobile Tel. No. |  |

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| ***CARER*** |
| Are you a carer ***for*** someone? | **YES** [ ]  | **NO** [ ]  |
| Name of person cared for |  |
| Are they registered with our practice? | **YES** [ ]  | **NO** [ ]  |
| Does this person have dementia? | **YES** [ ]  | **NO** [ ]  |
| Do you ***have*** a carer? | **YES** [ ]  | **NO** [ ]  |
| Name of carer |  |
| Are they registered with our practice? | **YES** [ ]  | **NO** [ ]  |

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| ***YOUR MEDICAL HISTORY AND PRESCRIPTIONS*** |  |
| Do you suffer from any significant illnesses? | **YES** [ ]  | **NO** [ ]  |
| If ‘yes’ please give details |  |
| Do you suffer from any allergies? | **YES** [ ]  | **NO** [ ]  |
| If ‘yes’ please give details |  |
| **PLEASE ATTACH A LIST OF YOUR REPEAT MEDICATION (obtainable from your current GP Practice)** |
| If living in Clitheroe, please nominate a local pharmacy to deal with your repeat medication requests  |  |

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| ***FAMILY HISTORY*** |
| **CONDITION** | **YES** | **NO** | **FAMILY MEMBER** |
| Asthma | [ ]  | [ ]  |  |
| COPD/Emphysema | [ ]  | [ ]  |  |
| Heart Problems | [ ]  | [ ]  |  |
| Cancer (what cancer?) | [ ]  | [ ]  |  |
| Diabetes | [ ]  | [ ]  |  |
| High Blood Pressure | [ ]  | [ ]  |  |
| Stroke | [ ]  | [ ]  |  |
| Dementia | [ ]  | [ ]  |  |

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| ***LIFESTYLE*** |
| Height |  | Weight |  |
| Smoking Status | Never Smoked |[ ]  If Current Smoker: | How many per day? |  |
|  | Ex-Smoker |[ ]   | Type? | Cigarette |[ ]
|  | Current Smoker |[ ]   |  | Pipe |[ ]
|  | E-Cigarette |[ ]   |  | Cigar |[ ]
| Would you like stop smoking advice? | **YES** [ ]  | **NO** [ ]  |

**Please complete the alcohol questionnaire on the next page.**

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| ***LIFESTYLE CONTINUED*** |
|  |
| **Do you drink alcohol?** | **YES** [ ]  | **NO** [ ]  | **How many units per week?** |  |
| **Questions** | **0** | **1** | **2** | **3** | **4** | **Score** |
| **1.** 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 |  |
| **Only answer the following 3 questions if the answer above is Never (0), Less than monthly (1) or Monthly (2). Stop here if the answer is Weekly (3) or Daily (4)** |
| **2.** 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 |  |
| **3.** How often during the last year have you failed to do what was normally expected from you because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| **4.** Has a relative or friend, doctor or other 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 |  |
| **FAST SCORE (total of questions 1 to 4):** |  |
|  |  |
| **If the FAST score is 3 or more, complete the remaining questions below** |
| **5.** 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 |  |
| **6.** How many standard alcoholic drinks do you drink on a typical day when you are drinking? | 1-2 | 3-4 | 5-6 | 7-8 | 10+ |  |
| **7.** How often during the last year have you found that you were not able to stop drinking once you had started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| **8.** 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 |  |
| **9.** How often during the last year have you had a feeling of guilt or remorse after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| **10.** Have you or somebody else been injured as a result of your drinking? | No |  | Yes, but not in the last year |  | Yes, during the last year |  |
| **TOTAL AUDIT SCORE (ALL ABOVE QUESTIONS COMPLETED)** |  |
| **0-7 Lower risk, 8-15 Increasing risk, 16-19 Higher risk, 20+ Possible dependence** |

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| ***ONLINE ACCESS TO MEDICAL RECORDS*** |
| Would you like online access to book appointments, request medication and view your medical records? | **YES** [ ]  | **NO** [ ]  | (If yes, continue below) |
| *Please note, your patient access details will be emailed to you once you have been registered. This can take up to 5 working days.* |
| Would you like access to your historical medical records? i.e. anything before you joined The Castle Medical Group | **YES** [ ]  | **NO** [ ]  | (If yes, read and sign the consent section below) |
| Would you like to nominate a proxy user to have access to your records on your behalf? i.e. a carer/parent | **YES** [ ]  | **NO** [ ]  | (If yes, continue to proxy access below) |
| ***PROXY ACCESS**** **Photo ID is required for both patient and proxy representative.**
* **The Patient’s consenting signature is required for all Proxy Access requests (if the patient lacks capacity the parent/care/legal guardian should be prepared to explain why a signature cannot be obtained).**
* **Parents may request a proxy access to their children’s records but access will be removed when a competent child reaches the age of 11; at this stage the patient may apply for access to their own record.**
 |
| Representatives Name |  | Date of Birth |  |
| Relationship to Patient |  |
| Address | House Name/Flat Number |  |
| Number and Street |  |
| Locality and Town |  |
| County |  |
| Postcode |  |
| Home Tel. No. |  | Mobile Tel. No. |  |
| Email Address |  |
| ***PATIENT CONSENT*****PLEASE READ THE STATEMENTS BELOW BEFORE SIGNING*** **I have read and understood the information leaflet provided by the practice.**
* **I will be responsible for the security of the information that I see or download.**
* **I understand the risks of allowing someone else to have access to my health record.**
* **If I choose to share my information with anyone else, this is at my own risk.**
* **I reserve the right to reverse any decision I make in granting proxy access at any time.**
* **I accept the practice retains the right to revoke online access if functionality is abused.**
* **I will contact the practice if I suspect that my account has been accessed by someone without my agreement or see information in my record that is not about me or is inaccurate.**
* **I agree that online access to sensitive or potentially harmful information may be restricted or refused when:**
1. **Sensitive information cannot be redacted.**
2. **The information may cause harm to the patient or any third party.**
3. **Concern exists relating to a patient’s potential to react violently to sensitive information.**
 |
| Patient Name |  |
| Patient Signature |  |
| Date |  |

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| **FOR OFFICE USE ONLY** |
| **Proof of ID** |  |
| **Proof of Address** |  |
| **Named GP Informed** |  |