NEW PATIENT QUESTIONNAIRE 11-15 Yrs

Please fill out all pages

Title:_____**Surname:** _____ **Forename(s):** _____

Sex: Male Female (circle) **D.O.B** _____

Mother's Name:_____ **Father's Name:** _____

Do they have parental responsibility ☐ *Do they have parental responsibility* ☐

Mother's Tel: _____ **Fathers' Tel:** _____

Home Tel: _____ **Child's Mobile Tel:**_____

Address of parent with responsibility who may not be living with child: _____

_____

Next Of Kin: Name:_____**Relationship:**_____

Contact No: _____

My child is an immediate family member of a Military Veteran? Y/N (Circle)

Patient Ethnic Origin Questionnaire

This questionnaire follows the recommendations of the *Commission for Racial Equality* and complies with the Race Relations Act. Please indicate your child's ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

Please record the MAIN SPOKEN language you use: _____

I require a language interpreter ☐ **I require a BSL interpreter** ☐

Choose ONE section from A to F and circle ONE box to indicate your background

A) WHITE	British	Irish	Any other white back ground: #9i2	
B) MIXED	White & Black Caribbean #9i3	White and Black African #9i4	White and Asian #9i5	Any other mixed background #9i6
C) ASIAN OR ASIAN BRITISH	Indian	Pakistani	Bangladeshi	Any other Asian background #9iA
D) BLACK OR BLACK BRITISH	Caribbean #9iB	African #9iC	Any other black background:9iD	
E) CHINESE OR OTHER ETHNIC GROUP	Chinese	Any other ethnic group #9iF		
F) DECLINED	#9SD			

Measurements

Height:_____**Weight:** _____

MEDICAL HISTORY: *Please list all significant medical problems where possible, e.g.*

Major Operations, Diabetes, Asthma, Heart Disease, Strokes

FAMILY HISTORY *Have any of your Parents, Brothers or Sisters suffered from Heart Disease, Diabetes, Asthma, High Blood Pressure or Strokes? If yes, please give their ages, relationship to you and age at diagnosis:*

MEDICATION : *Please list all medication you are currently taking*

ARE YOU ALLERGIC TO ANY DRUGS:

VACCINATIONS :

Is your child up to date with their vaccinations? Y/N (Circle)

SMOKING HISTORY

Do they smoke? Y/N (Circle)

If yes, how many per day? _____

Administration:

My child already uses EPS and wants to continue to use the following pharmacy: _____

I Consent to my child using the Electronic Prescription Service: **Y/N** (Circle)

Please send my child's prescriptions to the following pharmacy: _____

PLEASE NOTE: In order to maintain the confidentiality of this patient's medical record, parents/ guardians mobile number(s) will not be saved to this patient's record and you will not be able to register for Proxy Access

Parent's Name: _____

Parent's Signature: _____

Date: _____

Office use only	
Staff Initials	
Date handed in	
Co. signed by	
Date entered on EMIS	

Opt In/Out Patient Choice Form

For more information on data sharing please see our web site under GDPR and also www.nhsdatasharing.info.

Please tick the following if you wish to **OPT-IN**

Please note that by opting out of the SMS Texting ,EMAIL or Telephone notifications, you will not receive appointment reminders or health information

To receive SMS text reminders for appointments and health promotion information	YES	☐	NO	☐
To receive Email reminders for appointments and health promotion information	YES	☐	NO	☐
To receive telephone reminders for appointments and health promotion information	YES	☐	NO	☐

***IMPORTANT INFORMATION ABOUT YOUR HEALTH RECORD (Please read carefully)**

The NHS shares data from your medical record in a number of ways. You have the right to control how your personal information is used and who has access to it. You can opt out of this data sharing by completing the form below. We will then add relevant coding to your record to stop the extraction and processing.

I agree to the following information to be extracted and uploaded from my GP record for the following purposes:

National Data Opt-Out

This information is used by NHS England and Public Health England to determine future demand on services, or for research into the treatment of conditions. This will also include the National Diabetic Audit and other National Audits that the practice may part in. **(**https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/national-diabetes-audit)

To **Opt Out** of this please visit ***https://www.nhs.uk/your-nhs-data-matters/*** *where you will need to register your preference not to take part.* ***We cannot do this for you.***

The following options are for data sharing related to your direct health care. It is important you let us know your choices. You have the right to change your mind at any time

The Summary Care Record— Please opt me out of the Summary Care Record	**YES**	☐	**NO**	☐
(*If you have selected YES to the above option do not tick the 2 options below)*				
I Express consent for medication, allergies and adverse reactions only.	**YES**	☐		
I Express consent for medication, allergies, adverse reactions and additional information.	**YES**	☐		

The Summary Care record is a national record which can be accessed by healthcare professionals who may need to treat you in other parts of the country. It contains information on your main diseases, medications ,allergies, immunisations, care plans and significant medical history (past and present) which may be crucial to your care in an emergency situation**.** If you do not want your data to be available to other services on the national spine, please let the practice know and we will ensure you are **Opted out** of this data sharing

The Care and Health Information Exchange, (CHIE) - Please Opt me out of the Hampshire CHIE **YES** ☐ **NO** ☐

CHIE is a Hampshire wide database which healthcare professionals in other practices and the local hospitals can access if they need to treat you. They can ask you to view your practice record, such as when you visit a local Hub – and this may be important to providing you with the correct care. It is not available to health services outside of Hampshire – who would use the Summary Care Record to obtain important information about you.

I understand that I can opt my child in/out to any or all of these databases at any time in the future by informing the Practice in writing.

Patient Name: _____ Parent Name: _____

Parent Signature: _____ Date: _____