*Dr R Kapur and Partners*
*193 Narborough Road*
*Leicester*
*LE3 0PE*
**Tel: 0116 291 5355**
**Fax: 0116 247 0490**

## NEW PATIENT REGISTRATION / HEALTH QUESTIONNAIRE

Thank you for applying to join **Narborough Road Surgery Dr R Kapur and Partner** We would like to gather some information about you and
ask that you fill in the following questionnaire in addition to the GMS1 form. You don't have to supply answers to all of the questions but what you do fill in will help us give you the best possible care.

Please complete all areas in **CAPITAL LETTERS** and tick the appropriate boxes. Fields marked with an asterix (*) are mandatory.

| | |
|---|---|
| *Title *Surname | *First names |
| *Any previous surname(s) | *Date of Birth |
| *☐Male ☐Female | *NHS No. ☐☐☐☐☐☐☐☐☐☐ |
| Town and country of birth | *Home address<br><br>*Postcode |
| *Home telephone No. | |
| Work telephone No. | |
| *Mobile No. (if you have one) | Email address |

**Previous address and doctors details**

| | |
|---|---|
| *Previous address in the UK<br><br>Postcode | Name of previous doctor while at that address<br><br>Address of previous doctor |

**If you are from abroad**

| | |
|---|---|
| *Your first UK address where you registered with a GP if you were previously living abroad<br><br>Postcode | *If previously a resident in the UK, date of leaving<br><br>*Date you first came to live in the UK if applicable |

**If you are returning from the Armed Forces**

| | |
|---|---|
| Address before enlisting<br><br>Postcode | Service or Personnel No.<br><br>Enlistment date |

**Additional details about you**

*Main spoken languages

☐ **English**

☐ **Other** (please specify)

Interpreter required?

☐ Yes ☐ No

*What is your ethnic group? (Choose an option that best describe your ethnic group or background)

| | | | | | | |
|---|---|---|---|---|---|---|
| **White** | ☐ | English/Welsh/Scottish | ☐ | Northern Irish | ☐ | Irish |
| **Black** | ☐ | Caribbean | ☐ | African | ☐ | Other |
| **Asian** | ☐ | Indian | ☐ | Pakistani | ☐ | Chinese |
| **Mixed** | ☐ | White + Black Caribbean | ☐ | White + African | ☐ | White + Asian |
| **Other** | ☐ | *Please specify*: | | | | |

* Which of the following best describes you?

| | | | |
|---|---|---|---|
| Bisexual | ☐ | Transgender gender reassignment patient | ☐ |
| Male homosexual | ☐ | Transgender gender identity disorder | ☐ |
| Female homosexual | ☐ | | |
| Hetrosexual | ☐ | | |

*Do you have a Disability? ☐Yes ☐No

If yes, please tell us how we can support your need:

* Do you have a communication need that is related to your disability? ☐Yes ☐No

If you have answered yes, please tells us what communication need you have:

| | | |
|---|---|---|
| ☐ Use hearing loop | ☐ Use lip speaker | ☐ Use hearing aid |
| ☐ Use British Sign Language | ☐ Use cued speech cued transiliteraor | ☐ Use alternative communication skill |
| ☐ Use Makaton Sign Language | ☐ Use deaf-blind intervener | ☐ Use Sign Language |
| ☐ Use text phone | ☐ Use communication device | ☐ Use manual note taker |
| ☐ Use speech to text reporter | ☐ Personal Communication Passport | |
| ☐ Other | If Other, please tell us how we can support your communication need: | |

*Do you require information in a preferred format? ☐Yes ☐No (Choose below)

If you have another specific communication need please specify:

| | | |
|---|---|---|
| ☐ Requires contact by telephone | ☐ Requires contact by email | ☐ Requires contact by text relay |
| ☐ Requires contact by letter | ☐ Requires information in Makaton | ☐ Requires information in braille |
| ☐ Requires information in large font | ☐ Requires information in EasyRead | ☐ Medicine labelling large print |
| ☐ Requires audible alert | ☐ Requires visual alert | ☐ Requires tactile alert |
| ☐ Requires communication partner | ☐ Deafblind communicator guide | ☐ Face the client communicating |
| ☐ Interpreter needed -BSL | ☐ Deafblind telephone user | ☐ Other, please tell us: |

**Teaching & Training Practice**

Our practice is a teaching and training practice. You may be seen by a Medical Student or a GP Registrar or there maybe students present during your consultations with the clinicians. Please let the reception know when you come in for your appointment if you do not wish to have the presence of students during your consultation.

**Please tick if you would like to have a medical student present** **Yes** ☐ **No** ☐

**Data Sharing**

**Summary Care Record (SCR)**
The SCR is a summary of your medical history that can be shared between healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information. **More information can be found by visiting www.nhscarerecords.nhs.uk**

**Tick this box if wish to opt-out of the SCR** ☐

*Do you consent to receive the following types of communication from Dr R Kapur & Partner's Surgery

**Email** ☐Yes ☐No

**Mobile phone text messages** ☐Yes ☐No

**Answering machine messages** ☐Yes ☐No

**Medical Interoperability Gateway (MIG)**
Whilst the SCR mentioned above shares a very small portion of your medical record across the whole NHS, the MIG shares a much fuller view of your records but only with local NHS providers – and only when you give explicit consent at the point of care.
**For more information please visit our website at - https://www.narboroughroadsurgery.co.uk/**

**Tick this box if you wish to opt-out of the MIG** ☐

**Risk Stratification Preferences**
Risk Stratification patient data is shared between primary care and secondary care NHS providers and only when consent has been given at the point of care. **For more information please visit our website at www.narboroughroadsurgery.co.uk**

**Tick this box if you wish to opt-out of the Risk Stratification patient data use** ☐

**Electronic Data Sharing Module (EDSM)**
Healthcare places can usually share information from your records by letter, email, fax or phone but this can slow down your treatment or mean information is hard to access. However you can choose to share your record electronically between care services. **For more information please visit our website at www.narboroughroadsurgery.co.uk**

**Tick this box if you wish to opt-out of the EDSM** ☐

Do you have a Carer? ☐Yes ☐No
If yes, what is their name and contact number?
Do you consent for your carer to be informed about your medical care? ☐Yes ☐No

Are you a Carer? ☐Yes ☐No
If yes, do you look after someone who is a patient of Dr R Kapur & Partners ☐Yes ☐No ☐ Don't know
If yes, what is their name?
Are they a: ☐Relative ☐Friend ☐Neighbour

**Next of kin**

| Name of next of kin | Relationship to you |
|---|---|
| Next of kin telephone number(s) | Next of kin address (if different to above) |

**Medical details**

**In order to continue to receive your repeat medications you'll need to make an appointment with a GP at least one week before your next prescription is due.**

*Are you allergic to any medicines? ☐ Yes ☐ No (if yes please specify)

*List other allergies (pollen, animal hair or certain foods. Please mark "none" if you have no other allergies that you know of)

**If you are applying on behalf of a child who is in foster care/residential care/Kinship care/ or who is not your child**

Who has the legal responsibility for the child?

☐ You as the legal parent or guardian

☐ **Other** (please specify)

_____

Who can consent for the medical treatment for the child?

☐ You as the legal parent or guardian

☐ **Other** (please specify)

_____

**Looked after Children**

Are you looking after someone else's child? ☐ Yes ☐ No
If Yes, under what arrangements:
☐ Section 20-Voluntary Care ☐ Interim Care Order ☐ Care Order
☐ Child arrangement order/Residence Order ☐ Special Guardianship order
☐ Placed for adoption
☐ Private arrangement/Private Fostering/informal arrangement
(please note you have a duty to notify social care of this arrangement)

**Please tell us about your smoking habits**

Do you smoke? ☐ Yes ☐ No
If Yes, what do you primarily smoke:
☐ Pipe ☐ Cigarettes ☐ Cigar ☐ Other
How many do you smoke a day? _____
Would you like advice on quitting?
☐ Yes ☐ No

**Please tell us about your alcohol consumption**

| **Questions** (please circle your answers) | **Unit 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 - 4 times per | 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 |
| 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 |
| How often during the last year you failed to do what was normally expected from you because of your 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 had a feeling of guilt or remorse after drinking? | 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 somebody 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 or friend, Doctor or other Health worker been concerned about your drinking or suggested you cut down? | No | | Yes, but not in the last year | | Yes, during the last year |

| 1 UNIT | 1.5 UNITS | 2 UNITS | | 3 UNITS | 9 UNITS | 30 UNITS |
|---|---|---|---|---|---|---|
|  Normal beer half pint (284ml) 4% |  Small glass of wine (125ml) 12.5% |  Strong beer half pint (284ml) 6.5% |  Medium glass of wine (175ml) 12.5% |  Strong beer Large bottle/can (440ml) 6.5% |  Bottle of wine (750ml) 12.5% |  Bottle of spirits (750ml) 40% |
|  Single spirit shot (25ml) 40% |  Alcopops bottle (275ml) 5.5% |  Normal beer Large bottle/can (440ml) 4.5% | |  Large glass of wine (250ml) 12.5% | | |

**Please provide information below**

| | | |
|---|---|---|
| Height | ft | in |
| Weight | st | lb |
| Waist measurement | in | |

(**for women aged 25 to 64**) Have you had a cervical smear test?

☐ Yes ☐ No

If Yes Please state where, when and the result(if known)

## Please record any additional information about you that you think is important for us to know

**(Additional information includes: Social worker involved with your family; legal parental responsibilities of minor under 16 years old; applicant is in foster care or is adopted; if you are from overseas and claiming asylum or are a refugee)**

**NHS Organ Donor Registration**

"I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death". Please tick the boxes that apply.

☐ Any of my organs and tissue or…

☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

**For more information, please visit the website *www.uktransplant.org.uk* or call 0300 123 23 23**

***Signed**

***Date** (dd/mm/yyyy) / /

**Signed on behalf of patient** (*if applicable*)
(Minors under 16 years old, adults lacking capacity)

**Full Name:**

**Relationship:**

## On-line services

If there are any problems with your registration we will contact you to clarify any issues, but once your details have been entered into our computerised records you will be able to register with our **on-line service** provider (System One) and access appointments, prescriptions and some sections of your own medical record via the internet. All of the details that you need for this are available on our practice website at **www.narboroughroadsurgery.co.uk** - on the 'appointments' and 'prescriptions' icons on the home page.

**FOR OFFICE USE ONLY**

**PHOTO ID/Birth Certificate** (Over 18 only) ☐ **TYPE:** _____

| | | |
|---|---|---|
| **ADDRESS ID** | ☐ | **TYPE: _____** |
| **Other** | ☐ | **TYPE: _____** |