FOR OFFICE USE: Received by …….. (Receptionist Initials) Checked by …….. (Initials)

# STAPLOE MEDICAL CENTRE
# NEW PATIENT INFORMATION

Please complete all sections

**Full Name** (Mr, Mrs, Miss, Ms) ……..
**Date of Birth** ……..**Place of Birth** ……
**Contact Tel No Home**……..**Mobile** ……
**E-mail address**……
Please tick the box if you do NOT wish to be contacted via SMS on the above mobile number for appointment reminders etc. ☐ *(We will not use your number for any marketing purposes)*
**Tel No Work** ……..**Occupation** ……

**Next of Kin Name, Address, Tel No & relationship**……
……**Relationship**……
**Do you give consent for anybody to discuss your medical records**?
**Name**…….. **Relationship**……
**Is there a Last Power of Attorney in place for Health and Welfare?** Yes/No If yes please provide a copy
**Are you a Full Time Carer** YES/NO If yes for whom ……Relationship……

**Your Height**…….**Weight**……**Blood pressure checked in last year**? YES/NO
**Any Past Medical History e.g. Diabetes, Heart Disease, Hypertension, Asthma etc.**
……
**Current Medication** ……
……
**Allergies** ……

**Religion: Please circle which one best applies to you.**

Church of England Catholic Jewish Muslim Hindu Sikh
Christian Atheist Agnostic Jehovah's Witness Buddhist Other

**Ethnic Origin: Please circle which one best applies to you.**

British White European Polish Baltic Estonian/Latvian/Lithuanian Romanian
Portuguese Other White Ethnic Group Black Caribbean Black African Other Black Ethnic Group
Indian Pakistani Bangladeshi Chinese Other Asian Ethnic Group Other Ethnic Group

**SMOKING STATUS**

Tick the relevant box:

| | | | | | |
|---|---|---|---|---|---|
| Never Smoked Tobacco | | | Ex-Smoker Quit Date | | |
| Current Smoker | 1-9 per day | | Amount Smoked in past | Ex 1-9 per day | |
| | 10-19 per day | | | Ex 10-19 per day | |
| | 20-39 per day | | | Ex 20-39 per day | |
| | 40+ per day | | | Ex 40+ per day | |
| Rolls Own Cigarettes | | | User of Electronic Cigarette | | |
| Cigar Smoker | | | Ex User of Electronic Cigarette | | |
| Pipe Smoker | | | | | |

Smoking Cessation advice available from:
CAMQUIT – 0800 018 430
STAPLOE MEDICAL CENTRE – 01353 624123
STAPLOE PHARMACY – 01353 727695

Please turn over

Which description most closely matches your typical level of exercise? Please tick relevant box.

| | |
|---|---|
| Exercise physically impossible | |
| Avoid trivial exercise | |
| Light exercise | |
| Moderate exercise | |
| Heavy exercise | |
| Attend exercise class | |

Please fill in the "Your score" box for the following alcohol questionnaire.

| Questions | Scoring system | | | | | Your score |
|---|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 | |
| 1) 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 | |
| 2) 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+ | |
| 3) 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 | |
| 4) 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 | |
| 5) 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 | |
| 6) 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 | |
| 7) 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 | |
| 8) 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 | |
| 9) 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 | |
| 10) 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 | |

**Your health record and sharing of information**

This page provides information about the choices you can make about sharing your health record.
Your health record includes your medical history, details about your medication and any allergies you may have. You can now choose whether to share these full medical records.
We use a secure electronic health records systems called SystmOne. With your permission, this system can allow clinicians to share your full record held here with other healthcare services who are providing care for you. These other services will ask your permission to view your record.
Many organisations may use SystmOne including some GP practices, out of hours services, children's services, community services and some hospitals. Sharing your health record will help us deliver the best level of care for you.
You have two choices which allow you to control how your record is shared. You can change these choices at any time by letting the relevant practice or service know.
Please contact the Patient Experience Team on 0800 279 2535 or capccg.pet@nhs.net if you have any queries.
**Please note:** if you have previously opted out of sharing your information via the Summary Care Record, you will still need to complete this form with your choices about sharing your health record within SystmOne.

For further details visit www.cambridgeshireandpeterboroughccg.nhs.uk

**Sharing OUT –** This controls whether your information recorded at this practice or service can be shared with other healthcare services.
**Sharing IN** – This determines whether or not this practice or service can view information in your record that has been entered by other services who are provdigin care for you, or who may provide care for you in the future.

The choices you would like to make about sharing your health record:

**SHARING OUT**
I would like my health record at this practice or service to be shared with other healthcare services providing care for me

Yes ☐ No ☐

**SHARING IN**
I would like this practice or service to be able to view information in my health record that has been recorded by other healthcare services

Yes ☐ No ☐

Signature…… Date of Birth……

Print Name…… Date……