**Springfields Medical Centre**

**Bath Street Health & Wellbeing Centre Legh Street Warrington WA1 1UG**

**Tel 01925 303250**

**e-mail** [**warccg.springfieldsmc@nhs.net**](mailto:warccg.springfieldsmc@nhs.net)

**website –** [**www.springfieldsmedicalcentre.co.uk**](http://www.springfieldsmedicalcentre.co.uk)

**ADULT QUESTIONNAIRE**

**Thank you for applying to join Springfields Medical Centre. We would like to gather some information about you and ask that you fill in the following questionnaire.**

**You will need to supply TWO forms of identification (1 photographic ID such as a passport or driving licence and proof of address) with the completed questionnaire and GMS1 form**

**Name ………………………………………………………. DOB …………………………………………**

**Address ………………………………………………………………………………………………………..**

**…………………………………………………………………. Postcode ………………………………….**

**WHAT IS YOUR ETHNIC GROUP (please circle)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **White** | **British** | **Irish** | **Other white (please specify** |  |
| **Black** | **Caribbean** | **African** | **Other black (please specify)** |  |
| **Asian** | **Indian** | **Pakistani** | **Chinese** | **Other Asian**  **(please specify)** |
| **Mixed** | **White & black Caribbean** | **White & African** | **White & Asian** | **Oher mixed** |

**MAIN SPOKEN LANGUAGE (eg English, British Sign Language (BSL) …………………………………………**

**If you need help with reading/writing please indicate what support you require**

**…………………………………………………………………………………………………………………………………………..**

**CARERS INFORMATION**

**A carer is a friend/family member who gives their time to support a person in their home, to an extent that the person could not remain at home if the care was not being provided.**

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| **Do you have a carer Yes/No**  **If yes what is their name(s) and contact number (s)** |

**MEDICAL DETAILS (please tick or circle)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Epilepsy** | **Yes/No** | **Rheumatoid Arthritis** | **Yes/No** |
| **High Blood Pressure** | **Yes/No** | **Mental Illness (depression/anxiety)** | **Yes/No** |
| **Heart Attack** | **Yes/No** | **Diabetes (type 1 or 2)** | **Yes/No** |
| **Angina (stable/unstable)** | **Yes/No** | **Stroke** | **Yes/No** |
| **Transient Ischaemic Attack (TIA)** | **Yes/No** | **COPD or Emphysema** | **Yes/No** |
| **Cancer** | **Yes/No** | **Osteoporosis/bone fractures** | **Yes/No** |
| **Peripheral Vascular Disease** | **Yes/No** |  |  |

**FAMILY HISTORY**

**Do you have any family history of the following (please tick or circle)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **High Blood Pressure** | **Yes/No** | **Who** | **DVT/Pulmonary Embolism** | **Yes/No** | **Who** |
| **Ischaemic Heart Disease (diagnosed 60+)** | **Yes/No** | **Who** | **Breast Cancer** | **Yes/No** | **Who** |
| **Ischaemic Heart Disease**  **(diagnosed before 60)** | **Yes/No** | **Who** | **Any cancer (please specify)** | **Yes/No** | **Who** |
| **Raised Cholesterol** | **Yes/No** | **Who** | **Thyroid Disorder** | **Yes/No** | **Who** |
| **Stroke/CVA** | **Yes/No** | **Who** | **Epilepsy** | **Yes/No** | **Who** |
| **Asthma** | **Yes/No** | **Who** | **Osteoporosis** | **Yes/No** | **Who** |
| **Diabetes** | **Yes/No** | **Who** | **Other (please specify** | **Yes/No** | **Who** |

**MEDICATION**

|  |  |
| --- | --- |
| **Do you take any regular medication? Yes/No**  **If yes please specify** | **Please attach your repeat medication slip if you have this from your previous GP** |
| **Name** | **Dose (how many tablets per day)** |
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| **ARE YOU ALLERGIC TO ANY MEDICATION YES/NO – if yes please list below** |
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**ALLERGIES**

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| **List other allergies/intolerances (pollen, animal hair, food)** |

**DISABILITY/ACCESSIBILITY NEEDS (including hearing aids)**

**…………………………………………………………………………………………………………………………………………..**

**Please advise how we can support you? …………………………………………………………………………………………………………………………………………..**

**…………………………………………………………………………………………………………………………………………..**

**Please list any serious illnesses/operations/accidents/disabilities (women: any pregnancy related problems) and the approximate date**

**…………………………………………………………………………………………………………………………………………**

**…………………………………………………………………………………………………………………………………………**

**…………………………………………………………………………………………………………………………………………**

**SMOKING**

**Do you smoke Yes/No**

**If yes what do you smoke (cigarettes/pipe/cigar/vape) ……………………………………………………**

**How many do you smoke per day? …………………………………………………………………………………..**

**Would you like advice on quitting Yes/No**

**Are you an ex-smoker Yes/No**

**Approximately when did you quit? ………………………………………………………………………………….**

**ALCOHOL**

**1 unit = half pint of beer (4%) or single shot spirit (25ml, 40%)**

**1.5 units = strong half pint beer 6.5% or medium glass of wine (175ml/12.5%) or normal large bottle/can beer (440 ml 4.5%)**

**3 units = strong bottle/can of beer (440ml/6.5%) or bottle spirits (750ml/40%) or large glass of wine (250ml/12.5%)**

**Please circle your answers in the boxes below**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **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 week** | **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** |
| **Total** |  |  |  |  |  |

**IF YOU SCORE A TOTAL OF 5 OR MORE ON THE ABOVE QUESTIONS, PLEASE COMPLETE THE FURTHER 7 QUESTIONS BELOW**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **How often in 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 in the last year have you failed to do what was expected of you because of drinking?** | **Never** | **Less than monthly** | **Monthly** | **Weekly** | **Daily or almost daily** |
| **How often in the last year have you needed an alcoholic drink in the morning to get you going?** | **Never** | **Less than monthly** | **Monthly** | **Weekly** | **Daily or almost daily** |
| **How often in the last year have you had a feeling of guilt or regret after drinking?** | **Never** | **Less than monthly** | **Monthly** | **Weekly** | **Daily or almost daily** |
| **How often in the last year have you not been able to remember what happened when drinking the night before** | **Never** | **Less than monthly** | **Monthly** | **Weekly** | **Daily or almost daily** |
| **Have you or someone else been injured as a result of your drinking?** | **Yes/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 that you cut down?** | **Yes/No** |  | **Yes but not in the last year** |  | **Yes during the last year** |

|  |
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| **Your total score for ALL 10 questions indications the following:**  **0-7 = sensible drinking 8-15 = hazardous drinking**  **16-19 = harmful drinking 20+ = possible dependence**  **Would you like information or advice about alcohol consumption Yes/No** |

**EXERCISE**

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| **Do you exercise regularly Yes/No**  **If yes, what exercise do you take and how often:** | |
| **Height …….feet …………inches**  **Weight …….stone ………..pounds** | **For Women Only**  **Have you had a cervical smear?**  **Yes/No – please state where, when and the result if possible** |

**NEXT OF KIN/EMERGENCY CONTACT**

|  |
| --- |
| **Name/Address/Tel Number**  **Relationship to you** |
| **Name/Address/Tel Number**  **Relationship to you** |

**COMMUNICATION PREFERENCES**

|  |
| --- |
| **We may want to contact you by e-mail, send appointment reminders to your mobile and leave messages on your answer machine, if you have one**  **Tick the boxes if you are happy to be contacted**  **e-mail SMS Answer Machine Letter**  [Grab your reader’s attention with a great quote from the document or use this space to emphasize a key point. To place this text box anywhere on the page, just drag it.]  **Please tell us which method of contact listed above is preferred …………………………………..** |

**ACCESSIBLE INFORMATION STANDARD**

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| **Please use this space to tell us about any specific communication needs you have ie needing information in large print or deaf/blind. For further information visit** [**https://www.england.nhs.uk/ourwork/accessibleinfo/**](https://www.england.nhs.uk/ourwork/accessibleinfo/) |

**DATA SHARING**

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| **SUMMARY CARE RECORD**  **We would like to recommend that you take advantage of the Summary Care Record (SCR). The core SCR includes important information about your health, medicines you are taking, allergies you suffer from and any bad reactions to medicines**  **You can also choose to have additional information included in your SCR, which can improve the care you receive. This information includes:-**  **Your illnesses and health problems**  **Operations and vaccinations you have had in the past**  **How you would like to be treated – such as where you would prefer to receive care, what support you might need and who should be contacted for more information about you**  **You may need to be treated by Health and Care Professionals outside of the Practice who do not know your medical history. Having the additional SCR can help the staff involved in your care access information more quickly, allowing them to make informed decisions about your healthcare. More information can be found by visiting** [**www.nhscarerecords.nhs.uk**](http://www.nhscarerecords.nhs.uk)**.**  **Tick this box if you with to OPT IN to the core SCR**  **Tick this box is you wish to OPT IN to the core and additional SCR**  **Tick this box if you with to OPT OUT from the SCR** |

**MEDICAL INTEROPERABILITY GATEWAY (MIG)**

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| **Whilst the Summary Care Record (SCR) mentioned above shares a very small portion of your medical record across the whole NHS, the MIG shares a much broader view of your record but only with the local NHS providers and only when you give explicit consent at the point of care. For more information please visit https://healthcaregateway.co.uk/** |

**MENINGITIS ACWY IMMUNISATION**

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| **NHS England strongly recommends anyone who is starting University aged between 18 – 24 years, have an ACWY booster if you haven’t already done so.**  **Yes I would like a booster (if you tick this please talk to your University or call us to book an appointment)**  **No I would not like a booster**  **I have already had a Men ACWY booster on (date) …………………………………………………….** |

**DONOR REGISTER**

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| **NHS Organ Donor Registration**  **I want to register my details on the NHS Organ Donor Register as someone whose organs/tissues may be used for transplantation after my death**  **I consent for any of my organs and tissue or**  **Kidneys Heart Liver Corneas**  **Lungs Pancreas**  **On 20 May 2020, the law around organ donation in England was changed to allow more people to save more lives**  **Now that the law has changed, it will be considered that you agree to become an organ donor when you die, if:**   * **you are over 18;** * **you have not opted out;** * **you are not in an**[**excluded group**](https://www.organdonation.nhs.uk/uk-laws/organ-donation-law-in-england/#who)**.**   **For more information please visit** <https://www.organdonation.nhs.uk> |

**ON-LINE PATIENT ACCESS**

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| **Once your application to join our Practice has been accepted you’ll be able to order your repeat medications and book appointments. This service is known as Systmonline. To register for this service please visit,** [**www.springfieldsmedicalcentre.co.uk**](http://www.springfieldsmedicalcentre.co.uk)**, ask reception for an application form or complete the form attached.**  **You will need to bring the completed form to reception then you will be given a username and password**  **Each individual will need their own username and password.**  **You will be able to book an on-line TELEPHONE consultation, view and order your medication, view your test results, send the surgery a message.. You can also view your Summary Care Record unless you’ve chosen not to have one. You will also be able to see any allergies recorded, vaccinations, previous illnesses, hospital discharge summaries, appointment letters and referral letters**  **Ordering Medication on-line**  **Items that appear on your tick slip and medications that you have had from the surgery in the past will be listed on Systmonline.**  **Change of Contact Details**  **You can update us with your new address, telephone number, e-mail online. You can also consent to receiving text message reminders for things like appointments** |

**HOW TO ORDER YOUR REPEAT MEDICATION**

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| **For safety reasons, we do not take prescription requests over the telephone**  **There are a number of ways you can order your medication:-**  **On-line via Systmonline (you will need a username and password)**  **e-mail –** [**warccg.springfieldspx@nhs.net**](mailto:warccg.springfieldspx@nhs.net)  **Post your request to Springfields Medical Centre, Legh Street, Warrington WA1 1UG**  **Complete a prescription request form at the surgery**  **It takes 48 hours to process your medication. If we receive your request before 4 pm it will be ready within 48 hours after 4 pm.**  **Your GP will routinely review your medication and may ask you to arrange a review with our Clinical Pharmacist.**  **If you are due a medication review or health check and fail to attend, we reserve the right to reduce your medication until you have had your review.** |

**Nominated Pharmacy**

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| **The majority of prescriptions can be sent electronically to a Pharmacy of your choice. Please let us know your preferred Pharmacy and we can add this to your record.**  **Any questions regarding ordering your medication, please see our website** [**www.springfieldsmedicalcentre**](http://www.springfieldsmedicalcentre) |

**ARE YOU ELIGIBLE FOR NHS TREATMENT/HAVE YOU RECENTLY COME FROM ABROAD**

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| --- |
| Anybody in England can register with a GP practice and receive free medical care from that practice.  However, if you are not 'ordinarily resident' in the UK you may have to pay for NHS treatment outside of the GP practice. Being ordinarily resident broadly means living lawfully in the UK on a properly settled basis for the time being. In most cases, nationals of countries outside the European Economic Area must also have the status of 'indefinite leave to remain' in the UK.    Some services, such as diagnostic tests of suspected infectious diseases and any treatment of those diseases are free of charge to all people, while some groups who are not ordinarily resident here are exempt from all treatment charges.  More information on ordinary residence exemptions and paying for NHS Services can be found in the Visitor and Migrant patient leaflet\* available from your GP practice.  You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment. Even if you have to pay for a service, you will always be provided with any  immediately necessary or urgent treatment, regardless of advance payment.  The information you give on this form Will be used to assist in identifying your chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitals) and NHS Digital, for the purposes of validation, invoicing and cost recovery. You may be contacted on behalf of the NHS to confirm any details you have provided.  Please tick one of the following boxes:   1. 1 understand that I may need to pay for NHS treatment outside of the GP practice 2. I understand I have a valid exemption from paying for NHS treatment outside of the GP practice. This includes for example, an EHIC, Or payment of the Immigration Health Charge ("the Surcharge"), when accompanied by a valid visa. I can provide documents to support this when requested. 3. I do not know my chargeable status   I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.  **A parent/guardian should complete the form on behalf of a child under 16.**  Signed…………………………………………………………. Date ……………………………………………………  Print Name …………………………………………………………………………………………………………………  On Behalf of (patient name) ……………………………………………………………………………………….  Relationship to Patient ………………………………………………………………………………………………. |