OLD SWAN
HEALTH CENTRE GROUP PRACTICE

CRYSTAL CLOSE
LIVERPOOL
L13 2GA

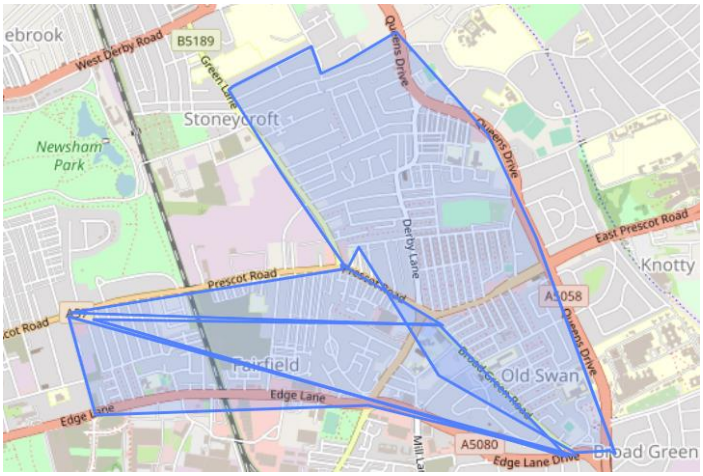
Please can you complete the enclosed patient questionnaire and return it to the surgery.
When completing this form please ensure that you give correct information, as we reserve the right to remove you from our practice register should you provide incorrect information.

Once you have completed all registration forms, please return them with the following forms of identification:

- **Photo Identification (E.g. Passport / Driver's License)**
- **Proof of Address (E.g. Utility Bill / Bank Statement)**

Please note: we will not accept a completed registration form without the above identification.

Once your registration form has been completed and checked, you will need to book an appointment for a new patient health check with a nurse or HCA in order to complete the registration process.
Please book this appointment with reception.



(Figure 1)

Please note: *we will not accept a new registration if your address is not in our* ***catchment area.***

Please see ***Figure 1*** *to check if your address falls in our catchment area.*

(For Admin use only)

ID TYPE	PLEASE INITIAL
GMS1 Fully Completed and Signed	
Patient Questionnaire Fully Completed	
Personal Identification Checked	
Proof of Address Checked	

This set of questions is designed to help your new doctor get to know you and your medical problems.
The information that you provide will be handled with the upmost confidentiality.
Thank you for taking the time to complete this questionnaire.

1. PERSONAL DETAILS	
Title:	
First Name(s):	
Surname:	
Marital Status:	
Date of Birth:	
Place of Birth:	
Home Address:	
Postcode:	
Home Phone N°:	
Mobile Phone N°:	
Work Phone N°:	
Email Address:	
Occupation:	

2. NEXT OF KIN	
Full Name:	
Relationship to you:	
Address:	
Phone N°:	

3. CONSENT		
In keeping with the Data Protection Act 2018, we must have your consent for the following actions:		
Do you consent for your NOK to be contacted in an emergency?	YES ☐	NO ☐
Do you consent for the surgery to leave messages on your answer phone?	YES ☐	NO ☐
Do you consent for the surgery to contact you via SMS?	YES ☐	NO ☐

Signature:		Date:	

3. CONSENT (CONTINUED)			
A Summary Care Record is a short summary of your GP medical records. Important basic parts of your medical record, like medication and allergies, can now be shared across the NHS to other health care providers who care for you. You can also opt to share some further key information such as long-term conditions, significant medical history, or specific communications needs.			
Do you consent for your basic medical record to be shared on the Summary Care Record?		YES ☐	NO ☐
Do you consent for your basic and **additional** medical record to be shared on the Summary Care Record?		YES ☐	NO ☐
OR alternatively, do you wish to **OPT OUT** from having a Summary Care Record?		YES ☐	NO ☐
Signature:		Date:	

4. CARER DETAILS			
If you are a carer, we would like to support you. For more information or guidance, please speak to your GP, or ask in the surgery what services are available to you.			
Are you a registered carer? (If **No** Skip to Part 5)		YES ☐	NO ☐
Name of person you care for:			
Relationship to you:			
Address:			

4. CARER DETAILS (CONTINUED)			
If someone else cares for you, it is important for us to hold this information in your medical record, please fill in the contact details below:			
Are you dependant on a carer? (If **No** Skip to Part 5)		YES ☐	NO ☐
Name of Carer:			
Relationship to you:			
Address:			
Phone N°:			

5. HEALTH INFORMATION					
Height:		Weight:			
Do you currently smoke?			YES ☐	NO ☐	
If **yes**, what do you smoke?	Cigarettes ☐	Cigars ☐	Pipe ☐	Roll Ups ☐	E-Cigarettes ☐
If **yes**, how often do you smoke per day?					
If **no**, have you ever smoked in the past?					
Approximate date stopped smoking:					
If you need any advice or support in regards to giving up smoking, please speak to either your GP or the practice nurse for further details on local smoking cessation services.					
Have you has a tetanus vaccination in the last 10 years?			YES ☐	NO ☐	
Approximate date of last tetanus vaccination:					
On average, how many days per week do you do **moderate** exercise? (E.g. Brisk walk, cycling, dancing, sport etc.)					
On those days, how much time did you usually spend on these moderate activities?					
How would you describe your diet?					
Do you have any specific dietary needs? (E.g. Gluten-Free, Vegetarian etc.)					

Alcohol Consumption Questionnaire						
Questions	**Scoring System**					**Your Score**
	1	**2**	**3**	**4**	**5**	
How often did you have a drink containing alcohol in the past year?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many standard units do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-8	10+	
How often do you have 6 or more standard units on one occasion in the past year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

A Score of 5+ indicates hazardous drinking habits. Please speak to your GP for further guidance and support.

Pint of regular beer/lager/cider (5%) = 2.9 units Single measure (25ml) of spirits = 1 unit Can (440ml) of lager (5%) = 2.2 units Bottle (700ml) of spirits (40%) = 28 units	Single measure (25ml) of spirits = 1 unit Bottle (700ml) of spirits (40%) = 28 units Glass (125ml) of wine (12%) = 1.5 units Bottle (750ml) of wine (12%) = 9 units

6. MEDICAL HISTORY			
Have you ever been diagnosed with the following conditions? (please give details in the box provided)			
Asthma:	YES ☐	NO ☐	
Diabetes:	YES ☐	NO ☐	
Epilepsy:	YES ☐	NO ☐	
Heart problems:	YES ☐	NO ☐	
High blood pressure:	YES ☐	NO ☐	
Please detail any other significant medical history: **(including illness, accidents, hospital admissions or operations)**			
Please list any current medication:			
Please list any allergies:			

7. WOMEN'S HEALTH				
Are you on any HRT or contraceptives?	YES ☐	NO ☐		
Have you had a cervical smear?	YES ☐	NO ☐	Date of last smear:	
What was the result of your last smear?				
Have you had a hysterectomy?	YES ☐	NO ☐	Date of procedure:	

8. FAMILY HISTORY				
Have any family or close relatives been diagnosed with the following illnesses or conditions?				
Asthma:	YES ☐	NO ☐	Relationship to you:	
Cancer:	YES ☐	NO ☐	Relationship to you:	
Diabetes:	YES ☐	NO ☐	Relationship to you:	
Epilepsy:	YES ☐	NO ☐	Relationship to you:	
Heart attack:	YES ☐	NO ☐	Relationship to you:	
High blood pressure:	YES ☐	NO ☐	Relationship to you:	
Stroke:	YES ☐	NO ☐	Relationship to you:	
Please detail any other significant family history:				

9. SPECIFIC NEEDS			
Do you have any Sensory impairment?	YES ☐	NO ☐	
Do you have an assistance dog that accompanies you?	YES ☐	NO ☐	
Do you have any physical or mental disabilities?	YES ☐	NO ☐	
Do you have any requirements to be able to access the Practice Premises?	YES ☐	NO ☐	
Do you have any other needs or requirements we may need to be aware of?	YES ☐	NO ☐	

Do you use any of the following communication aids? (Please tick all that apply)	
British Sign Language (BSL)	☐
Loop System	☐
VOCA	☐
Lip Reading	☐
Tadoma	☐
Minicom	☐

10. ETHNICITY DATA

As part of our registration process all new patients are asked to complete the following questions about their ethnic background. We provide services to a diverse and multi-cultural community and we ask new patients their ethnic category so that we can better meet their cultural, religious and language needs. We also request information in regards to individual needs so that we can better support you.

Please note: Answering the following questions is not compulsory, but may help with you healthcare. These questions may only be completed by the registering person, or a parent/guardian in regards to children.

Why do we need this information?
- To understand the needs of patients from different groups and provide better and more appropriate services.
- To identify patients who are at risk. Some groups are more at risk for specific diseases and knowing your origins may help with early identification.
- To comply with the Equality Act 2010, this is a legislative requirement for public authorities to promote race equality. We are required to monitor the ethnic group of ALL patients to identify who might be at a greater risk from specific diseases or conditions, and to ensure that no racial discrimination occurs.

The information that you provide will be treated as part of your confidential medical record. The NHS has strict standards regarding data protection and your information will be carefully safeguarded. Any information used in the planning of services will be unidentifiable (i.e. identifying factors and details removed).Once you have provided the following information, you will not be asked these questions again.

Please choose ONE section from 1-7 and indicate your ethnic category. If your ethnicity is not listed, then please use the boxes indicated to provide us with this information. If you do not wish to inform us of your ethnic category, go straight to section 11.

SECTION 1: White background			
British	☐		
Irish	☐		
Other White background	☐	**Please specify:**	
SECTION 2: Mixed background			
White and Black Caribbean	☐		
White and Black African	☐		
White and Asian	☐		
Other Mixed background	☐	**Please specify:**	
SECTION 3: Asian or Asian British background			
Indian	☐		
Pakistani	☐		
Bangladeshi	☐		
Other Asian background	☐	**Please specify:**	
SECTION 4: Black or Black British background			
Caribbean	☐		
African	☐		
Other Black background	☐	**Please specify:**	
SECTION 5: Chinese			
Chinese	☐		
SECTION 6: Any other ethnic background			
Any other ethnic background	☐	**Please specify:**	
SECTION 7: Not stated			
Prefer not to say	☐		

11. LANGUAGE DATA

Please indicate your first language by ticking one of the boxes below.

012 English	☐	031 Kurdish	☐
001 Akan (Ashanti)	☐	032 Lingala	☐
002 Albanian	☐	033 Luganda	☐
003 Amharic	☐	034 Makaton (Sign Language)	☐
004 Arabic	☐	035 Malayalam	☐
005 Bengali & Sylheti	☐	036 Mandarin	☐
006 Brawa & Somali	☐	037 Norwegian	☐
007 British Sign Language	☐	038 Pashto (Pushtoo)	☐
008 Cantonese	☐	039 Patois	☐
009 Cantonese & Vietnamese	☐	040 Polish	☐
010 Creole	☐	041 Portuguese	☐
011 Dutch	☐	042 Punjabi	☐
013 Ethiopian	☐	043 Russian	☐
014 Farsi (Persian)	☐	044 Serbian/Croatian	☐
015 Finnish	☐	045 Sinhala	☐
016 Flemish	☐	046 Somali	☐
017 French	☐	048 Spanish	☐
018 French creole	☐	050 Swedish	☐
019 Gaelic	☐	051 Sylheti	☐
020 German	☐	052 Tagalog (Filipino)	☐
021 Greek	☐	053 Tamil	☐
022 Gujarati	☐	054 Thai	☐
023 Hakka	☐	055 Tigrinya	☐
024 Hausa	☐	056 Turkish	☐
025 Hebrew	☐	057 Urdu	☐
026 Hindi	☐	058 Vietnamese	☐
027 Igbo (Ibo)	☐	059 Welsh	☐
028 Italian	☐	060 Yoruba	☐
029 Japanese	☐	200 Other	☐
030 Korean	☐	**Please specify:**	
Do you require an interpreter?		YES ☐	NO ☐

12. RELIGION DATA

How would you describe your religion?

A1 Baha'i	☐	G1 Muslim	☐
B1 Buddhist	☐	H1 Pagan	☐
C1 Christian	☐	I1 Sikh	☐
C22 Church of England	☐	J1 Zoroastrian	☐
C44 Jehovah's Witness	☐	L2 Not Religious	☐
C67 Roman Catholic	☐	K20 Other	☐
D1 Hindu	☐	**Please specify:**	
E1 Jain	☐	M1 I do not wish to disclose my religion	☐
F1 Jewish	☐		