Kidderminster Medical Centre
Waterloo street, Kidderminster DY10 2B
Phone: 01562 546740 Fax: 01562 546770

New Patient Questionnaire

WELCOME TO OUR PRACTICE - Patients Under 14

First Name		**Last Name**	
Any previous First Names		**Any previous Last Names**	
Current Address		**Date of Birth**	
Post code		**Place of Birth**	
Previous Address & Post Code		**Tel: Home**	
		Tel: Mobile (parent/carer)	
Main spoken language		**Gender**	☐ **Male** ☐ **Female**
Mother's Full Name		**Mother's Date of Birth**	
Mother's Address (If different to patient's)		**Father's Full Name**	
Father's Address (If different to patient's)		**Father's Date of Birth**	
Name of Person(s) with parental responsibility		**Name of Primary Carer(s)**	
Name & Address of Previous Doctor		**Name of Previous Health Visitor**	
Name and Address of Current School		**Name and Address of Previous School**	
Ethnic origin	White British/Other white background/ White & Asian/Indian/Pakistani/ Other mixed/Other Asian background/ Caribbean/African/Chinese/ Other black background/Other/Refuse to disclose		

Have you received information on the Summary Care Record? (SCR is where your basic medical history is shared with hospitals across England in case of an Emergency)	☐ **Yes** ☐ **No**
Do you wish to opt out? (i.e. <u>not let any</u> information about you be available to hospitals, A&E or Out of Hours, if needed)	☐ **Yes** ☐ **No**

Do you consent to us contacting you by text and/or e-mail about your child?
☐ **Yes** by text and e-mail ☐ **Yes** by text only ☐ **Yes** by e-mail only ☐ **No**

Under the Data Protection Act we have to inform you that the contents of any e-mails will not be confidential and secure. Any information we obtain from you will be used only for us to communicate with you. This information will not be passed on to any third party and will not be kept for longer than necessary. Confidentiality and security cannot be guaranteed whilst in transit and all e-mails should contain the minimum of identifiable information. Any e-mails you send will be stored on your e-mail provider's server and should be deleted as soon as possible as the NHS have no control over these mail servers.

PLEASE NOTE: YOU CAN VIEW OUR PRIVACY NOTICE ON OUR WEBSITE: www.wyreforesthealthpartnership.co.uk.

Do you take any regular medications? ☐ **Yes** ☐ **No** (If **YES**, please attach copy of your repeat prescription request form)

Note: If you have nominated a specific pharmacy for your prescriptions you may need to change this to a more local pharmacy.

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Do you have any allergies to any drugs, food or other substances? ☐ **Yes** ☐ **No** (If **YES**, please give details)

❑ I need to carry an adrenaline pen

Have you, your parents, siblings suffered with any of the following (if YES who and at what age)?

Asthma/COPD		Heart Attack/Heart Disease	
Mini Stroke/Stroke/TIA		Epilepsy	
High Blood Pressure		Diabetes	
Glaucoma		Cancer	
Kidney Disease		Depression/Mental Health problems	
Learning Difficulties		Thyroid problems	
Osteoporosis		Atrial Fibrillation	
Dementia		Other	

Are you currently under Hospital Care?

Hospital Name Consultant

Nature of Problem

Are you childhood Immunisations Up-to-Date? DTP, Polio, Meningitis, Hib, Pneumococcal, MMR, Rotavirus

☐ **Yes** ☐ **No**

New patients or temporary registrations will not be accepted without proof of identification and proof of address. To register a child under-14 the parent/care will need to show the birth-certificate to complete the registration process.

This information will only be used by doctors and staff of the Medical Centre and will be treated with confidentiality.

Parent/Carer needs to sign and date the form.

Name_____ **Date**_____

For office use only

Two forms of identity seen? 1]
2]

Checked by:
Please inform the patient of their named GP and record it here