Kingswood Health Centre

New Patient Questionnaire

You will also need to complete a GMS1 Form for us to be able to register you as a patient.

Title:	
First Name:	**Last Name:**
Phone (Preferred): Home / Mobile / Work	**Phone (Alternate):** Home / Mobile / Work
Email: Please note Kingswood Health Centre does not accept any responsibility for the loss of confidential information should a patient's email account be intercepted by a third party.	
Online Access: If you would like to register for on-line services then please download the NHS app. Once registered this will allow you to be able to order prescriptions, book appointments and view a summary of your electronic medical record (See our practice leaflet for further information). Once the NHS app is downloaded this service will be available to you from the date of your registration with us. Please make sure that you sign and date this form and tick if you will be using the NHS app for online services	☐ YES (I would like to register for online access) ☐ NO (I would not like to register for online access)
Patient Messaging: As a practice we would like to communicate with our patients by SMS text messaging appointment reminders / email with practice newsletters – You may withdraw from this service at any time by contacting the Heath Centre. Please add your mobile details and/or e-mail address at the top of the form.	☐ I consent to receiving text messages ☐ I consent to receiving emails ☐ I do not consent to receiving text messages or emails
Summary Care Record: In light of the current emergency, the Department of Health and Social Care has removed the requirement for a patient's prior explicit consent to share Additional Information as part of the Summary Care Record. This is because the Secretary of State for Health and Social Care has issued a legal notice to healthcare bodies requiring them to share confidential patient information with other healthcare bodies where this is required to diagnose, control and prevent the spread of the virus and manage the pandemic. This includes sharing Additional Information through Summary Care Records, unless a patient objects to this.	☐ YES (I would like to apply to have a Summary Care Record) ☐ NO (I would like to opt out of having a Summary Care Record)

Allergies:	Do you have a disability or sensory loss? ☐ YES ☐ NO
Height:	Weight:

Do you smoke?	☐ YES ☐ NO	How many per day?	
Would you like help to give up?	☐ YES ☐ NO		
Do you drink alcohol?	☐ YES ☐ NO	How many units approximately per week?	☐ 1 - 5 ☐ 6 - 10 ☐ 11 - 20 ☐ 21+
Do you take regular exercise?	☐ YES ☐ NO	What type of exercise and how much?	

Current Medication:
Past Medical History:

Do you have a carer?	☐ YES ☐ NO
Carer's name and number:	
Are you a carer, but not as part of your paid job?	☐ YES ☐ NO
Name and number of the person you care for:	

Are you or have you ever been a member of the armed forces community?

- ☐ No
- ☐ Veteran
- ☐ Reservist
- ☐ Family (spouses, partners and dependents or serving Armed Forces personnel)

Ethnic Origin:

- ☐ White British
- ☐ African
- ☐ Asian
- ☐ Bangladeshi
- ☐ Caribbean
- ☐ Chinese
- ☐ Indian
- ☐ Irish
- ☐ Mixed white black African
- ☐ Pakistani
- ☐ Other white background
- ☐ Other mixed background
- ☐ Other

By ticking this box I declare that the information I have given on this form is correct to the best of my knowledge. ☐ (Please tick here)

Signature:

Date: