YEALM MEDICAL CENTRE

New Patient Questionnaire : Newborn – 16 years

Title:_____ Forename:___________________ Surname:__________________ Date of Birth: ______________

Address:____

Mobile Number:_________________ Landline:_________________

Email Address : ____

Please use your personal mobile number and email address. For data protection purposes we cannot record shared email addresses or mobile numbers.

Preferred Contact Method: ☐ Mobile ☐ Landline ☐ Email

Consent to SMS Messaging: ☐ Yes ☐ No ID Provided: ☐ Driving License ☐ Passport ☐ Utility Bill

---

GDPR and Data Sharing:

Summary Care Record (SCR):This record contains basic information about: Allergies you may have, unexpected reactions to medications and any prescriptions you have recently received. The intention of the SCR is to help clinicians in Emergency Departments and Out of Hours services to give you safe, timely and effective treatment. Clinicians will only be allowed to access your record if they are authorised to do so and, even then, only if you give your express permission. You will be asked if healthcare staff can look at your SCR every time they need to (unless it is an emergency i.e. you are unconscious.)

Please tick **one** of the following options:

☐ Express consent for medications, allergies and adverse reactions

☐ Express consent for medications, allergies and adverse reactions **and additional information**

☐ Express dissent (opt-out)

Clinical System Record Sharing: Due to GDPR, our clinical system, SystmOne (S1), also requires your permission to permit or restrict access to the information entered into your record at each organisation that accesses your record. You can change your consent at any time. Please tick your preferences:

Do you consent to the sharing of data recorded here with any other organisations that may care for you?

☐ Yes – share with other organisations ☐ No – do not share any data recorded at Yealm Medical Centre

Do you consent to the viewing of data by this organisation that is recorded at other care services that may care for you where you have agreed to make your data shareable?

☐ Yes ☐ No Please sign here to confirm your choices: __________________________________

Medical History:

Please list any current illnesses:

Are they currently housebound? ☐ Yes ☐ No

Do they have any environmental or drug allergies? ☐ Yes ☐ No If Yes, please list them: _________________

Do they have a disability, impairment or sensory loss? Please state diagnosis: _________________________

Please ensure you bring in the child's Red Immunisation Book so we can have an up to date record of their immunisations.

Safeguarding information:

Is there any relevant safeguarding history for this child? ☐ Yes ☐ No

If yes, please state (such as looked after child, adopted or known by CAMHS): :________________________

____

Family History: Have any of your close relatives suffered from any of the below:

High Blood Pressure (Hypertension) ☐ Yes ☐ No **Relation:** ____

Heart Disease under 60 years: ☐ Yes ☐ No **Relation:** ____

Heart Disease over 60 years: ☐ Yes ☐ No **Relation:** ____

Ethnic group: Please tick below your ethnic group.

◻ Arab ◻ Bangladeshi ◻ Chinese ◻ Indian ◻ Pakistani ◻ Black African ◻ Black Caribbean ◻ Irish Traveller ◻ Mixed Race ◻ Other Asian ◻ Other British Black ◻ Other White Background ◻ White and Asian ◻ White and Black African ◻ White and Black Caribbean ◻ White British ◻ White Irish

If you do not want ethnicity recorded please tick here: ☐

Please fill out your information and relationship to the child:

Name: __________________________________ Relationship to child: ______________________________

Date of Birth: ________________