

Fortrose Medical Practice

Partners: Dr Iain Forth, Dr Shona Forth, Dr Ross Grant & Dr Suzy Walker

Associate: Dr Sally Martin

Station Road	Phone:	01381 622000
Fortrose	Fax:	01381 622009
Ross-shire	Email:	High-UHB.GP55381-Reception@nhs.net
IV10 8SY	Website:	www.fortrosesurgery.co.uk

INVITATION TO VISIT FORTROSE MEDICAL PRACTICE FOR YOUR NEW PATIENT HEALTH CHECK

All patients over the age of five are invited to make an appointment as soon as possible at our practice, after completing our short questionnaire, for a health check with our Practice Nurse or Health Care Assistant. This is not compulsory but will give you as the new patient (or his/her parent/carer) the chance to find out about your new practice and to provide basic baseline health measurements for us such as blood pressure, height and weight. At the same time we can advise you about any matters relevant to your health and talk through any lifestyle changes you might wish to make which could reduce the risk of future health problems.

It can take some time to obtain your previous medical records and it is clearly important for us to know as much as possible about you, your medical history and any current issues from the outset. In the event of medical treatment needed in a medical emergency before your records come through from your previous practice, this could greatly help the doctors and could even save your life.

You may feel perfectly healthy and may also have had a health check elsewhere but we would still very much like to see you soon.

We look forward to hearing from you – and seeing you – soon.

Yours sincerely

Gaby Ormerod
Practice Manager

EMERGENCY CARE SUMMARY (ECS)

All patients in Scotland have, or will have something called an Emergency Care Summary.

This is a summary of basic information about your health which might be important if you need urgent medical care when your GP surgery is closed, or when you go to an accident and emergency department. It means that all NHS staff looking after you can get important information about your health, even if they cannot contact your GP surgery.

Your ECS contains the following information

- ❖ **Your name**
- ❖ **Your date of birth**
- ❖ **The name of your GP surgery**
- ❖ **An identifying number called a CHI number**
- ❖ **Information about any medicines prescribed by your GP surgery**
- ❖ **Any bad reactions you've had to medicines that your GP knows about**

Your ECS is copied from your GP's computer system and stored electronically. NHS staff can then find it quickly if they need to see it.

Who can look at my Emergency Care Summary?

- ❖ NHS staff can look at your ECS on computer if they need to treat you when your GP surgery is closed. They must ask you if you agree to this before they look at your information.
- ❖ If you agree, only the following staff will be able to look at your ECS
 - Doctors, nurses and receptionists in out-of-hours medical centres.
 - Staff at NHS 24 who are involved in your care.
 - Staff in hospital accident and emergency departments.
- ❖ In the future, ambulance staff may also be able to look at your ECS.
- ❖ If you are unconscious, NHS staff may look at your ECS without your agreement. This is so they can give you the best possible care.

How do I know that the information in my ECS is secure?

- ❖ The NHS stores your ECS electronically using the highest standards of security.
- ❖ Only NHS staff directly involved in your medical care will be allowed to look at your ECS.
- ❖ NHS staff can only look at your ECS if they have a password that allows them to.
- ❖ A record will be kept of everyone who has looked at your ECS.

What if I'm not sure that I want an ECS?

- ❖ If you don't want an ECS to be made for you, tell your GP surgery.
- ❖ Don't forget that if you do have an ECS, you will be asked if staff can look at it every time they need to. You don't have to agree to this.

Can I see my ECS?

- ❖ If you would like to see your ECS, ask your GP to print it out for you to have a look at.
- ❖ If you think anything is wrong, ask for it to be changed.

PATIENT QUESTIONNAIRE
FORTROSE MEDICAL PRACTICE

We thank you for taking the time to complete this question sheet. Please fill in as much as you can, as this will help us to provide you with the best possible care.

PERSONAL DETAILS

Last Name Maiden Name.....

First Name Marital Status

Address Date of Birth

..... Occupation.....

(Give previous if retired)

.....Postcode Employer.....

Telephone No

Mobile No.....

Do you consent to this number being used for communication from the practice? Yes No

Email

Do you consent to this email address being used for communication from the practice? Yes No

FAMILY HISTORY - Please tell us of any serious illnesses suffered by your close relatives.

Mother

Father

Brothers

Sisters

Children

PERSONAL MEDICAL HISTORY

Illness or operations

Current medical problems

Allergies

Immunisations (dates if known): Tetanus Polio Other

(For children under 5 – parents please bring along red book)

YOUR LIFESTYLE

- Do you smoke?** **Yes** **No** **If Yes** – how many per day?
How long have you smoked?
- Have you ever smoked?** **Yes** **No** **If Yes** – how many per day?
How long did you smoke?
- When did you stop smoking?
- Do you drink?** **Yes** **No** **If you do** – how many units per week?.....
(One unit = 1 measure of spirits, 1 glass of wine or ½ pint of beer)
- Have you ever ?** **Yes** **No** **If so** how many units per week and when
did you stop?
- Do you take regular exercise?** **Yes** **No** *(please give details)*

LADIES ONLY

Present contraception (pill, coil etc)

Year of last smear (if known)

Children’s dates of birth
.....
.....

EMERGENCY CARE SUMMARY (See attached leaflet)

Do you wish to opt out? **Yes** **No**

Patient’s Signature

Date.....

LOOKING AFTER SOMEONE

Do you look after or take responsibility for a parent, spouse/partner, child, relative, friend or neighbour who is unlikely to be able to manage at home without support? They may be frail due to sickness or old age, have a physical or learning disability, sensory impairment, mental health, drug or alcohol problems.

No Not sure Yes

Do you look after or keep an eye on:

1 person 2 people More than 2 people

Is this person/are these people your:

Grandparent Parent Spouse/partner Brother/Sister Child
Relative Friend Neighbour Other

In total, approximately how many hours per week do you look after, do chores for, or sort out problems for them?

1- 19 hours per week 20-49 hours per week over 50 hours per week

Do you know about the range of services, information, advice and support available for carers (people who keep an eye on, look after or take responsibility for someone)?

No Not sure Yes

BEING LOOKED AFTER

Does someone look after or keep an eye on you, because you are not able to manage at home without help?

No Not sure Yes

Is this person/are these people your:

Grandparent Parent Spouse/partner Brother/Sister Child
Relative Friend Neighbour Other

PATIENT ETHNIC ORIGIN FORM

This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act.

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

Choose ONE section below and then tick ONE box to indicate your background.

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

White

Scottish		9i21
British or Mixed British		9i0
Irish		9i1
Other White – please write below		9i2

Mixed

White and Black Caribbean		9i3
White and Black African		9i4
White and Asian		9i5
Any other mixed background please write below		9i6

Asian or Asian British

Indian or British Indian		9i7
Pakistani or British Pakistani		9i8
Bangladeshi or British Bangladeshi		9i9
Any other Asian background please write below		9iA

Black or Black British

Caribbean		9iB
African		9iC
Any other black background please write below		9iD

Chinese or other ethnic group

Chinese		9iE
Any other please write below		9iF
Declined / Not stated		9iG

Shaded areas for office use only

DIRECTIONS TO YOUR HOME

Name..... Date of Birth.....

Address

.....

If you think your GP or paramedics might have difficulty in finding your home in an emergency, please help us by drawing a map or giving directions below. Mention any distinctive features or exact distance from local landmarks. A photocopy of the OS map with your house marked would also work.

The information will be added to your notes and will be treated with the same degree of confidentiality as any other information we hold.

Repeat Medication

Your Name:

Your Date of Birth:

Is your medication issued in a Dosette Box? *Yes / No (please circle)*

Example

What is the **NAME** of your medicine? - eg. *Paracetamol*

What do you take the medicine for? - eg. *Back Pain*

What is the **STRENGTH** of your medicine? - eg. *500mg*

HOW MUCH of this medicine do you take at a time? - eg. *2 tablets*

HOW OFTEN do you take this medicine? - eg. *Four times a day if required for pain*

For each medicine that you use, please fill in one of the following boxes

What is the **NAME** of your medicine? -

What do you take the medicine for? -

What is the **STRENGTH** of your medicine? -

HOW MUCH of this medicine do you take at a time? -

HOW OFTEN do you take this medicine? -

What is the **NAME** of your medicine? -

What do you take the medicine for? -

What is the **STRENGTH** of your medicine? -

HOW MUCH of this medicine do you take at a time? -

HOW OFTEN do you take this medicine? -

What is the **NAME** of your medicine? -

What do you take the medicine for? -

What is the **STRENGTH** of your medicine? -

HOW MUCH of this medicine do you take at a time? -

HOW OFTEN do you take this medicine? -

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