



Litcham

HEALTH CENTRE

Manor Drive, Litcham, King's Lynn, Norfolk, PE32 2NW
Telephone 01328 701568 | www.litchamhealthcentre.co.uk
Email nsicb.litcham.surgery@nhs.net

New patient health questionnaire

For adults and children joining the practice

Complete this alongside the NHS online registration process or paper registration form PRF1. It helps us understand your health and support needs. Please always give your name and date of birth; other details already supplied on your NHS registration form do not need to be repeated here.

Complete one questionnaire per person. If completing it for a child, answer about the child. Write clearly and tick the relevant boxes. Ask reception if you need help, an interpreter or a different format.

Complete what you can. You may write "not known" or "not applicable", leave optional questions blank, or ask to discuss them privately. Missing health information should not delay registration. You do not need identification, proof of address, proof of immigration status or an NHS number to register.

1 Your details

Title (optional): _____ First name(s): _____

Surname: _____

Previous name(s): _____

Name you prefer us to use: _____ Date of birth: _____

Sex recorded on your NHS record, if known: _____

NHS number, if known: _____

Home address and postcode, or a safe correspondence address

If you have no fixed address, please tell reception so we can arrange a contact address.

2 Contact details

Mobile: _____ Other telephone: _____

Email: _____

These details belong to: ☐ Patient ☐ Parent or carer ☐ Other: _____

3 Information to help us plan your care

Please provide a recent medication list and any vaccination records you have. If relevant, include recent hospital letters, care plans or a service medical summary. Copies are helpful, but do not delay registration if you do not have these documents.

Details of your previous GP, previous address and any overseas registration information should be provided through the NHS registration process or PRF1.



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Contact preferences and support

Patient name: _____ Date of birth: _____

4 Keeping in touch safely

May we contact you about your healthcare using the details on page 1?

Text messages: ☐ Yes ☐ No Email: ☐ Yes ☐ No Voicemail: ☐ Yes ☐ No

Preferred contact method: ☐ Telephone ☐ Text ☐ Email ☐ Letter ☐ Other: _____

Any restrictions on messages, letters or contact details we should use?

If you would prefer to discuss safe contact arrangements privately, please tell reception.

5 Language and accessibility

Main language: _____ Interpreter needed: ☐ Yes ☐ No

Interpreter language, including British Sign Language if relevant: _____

Do you need support to read information, communicate or attend appointments?

☐ Large print ☐ Easy read ☐ Audio or Braille ☐ Communication support

☐ Step-free access ☐ Support at appointments ☐ Other ☐ No support needed

Tell us what would help, including any hearing, sight, learning or mobility needs

Are you housebound or do you need help to attend the surgery?

☐ Yes ☐ No ☐ Not sure

6 Emergency contact

Name: _____ Relationship: _____

Telephone: _____

Address: _____

Naming an emergency contact does not give them automatic access to your medical records. If you want someone to discuss your care or use online services on your behalf, please ask us to arrange this separately.

7 Carers and other support

Does anyone help care for you? ☐ Yes ☐ No

Carer name and relationship or organisation: _____

Carer telephone and address: _____

Do you provide unpaid care for someone? ☐ Yes ☐ No

Support you would like us to know about: _____



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Your health and medicines

Patient name: _____ Date of birth: _____

If you have an urgent health concern or may run out of essential medicine before your registration is complete, contact the surgery directly. Do not rely on this form to request urgent care or a prescription.

8 Allergies and reactions

Do you have any allergies or reactions to medicines, foods or other substances?

☐ Yes ☐ No known allergies ☐ Not sure

Medicine or substance	Reaction and how severe it was	Approximate date

9 Current medicines

Include prescribed medicines, inhalers, creams, contraception, medicines bought without a prescription and supplements. You can attach a recent medication list; note any changes and medicines prescribed by a hospital or private clinician.

Medicine name and strength	Dose and how often taken	Days of supply left

Usual pharmacy name and location: _____

10 Medical history and ongoing care

Health conditions, including physical or mental health conditions, and approximate dates

Previous operations or hospital admissions and approximate dates

Current specialists, referrals, tests or follow-up appointments you are waiting for

Relevant family medical history and your relationship to the person affected



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Children vaccinations and screening

Patient name: _____ Date of birth: _____

11 Children under 18

Complete this section if the patient is under 18. Otherwise go to section 12.

Parent or carer name: _____

Relationship to child: _____ Telephone: _____

Do you have parental responsibility? ☐ Yes ☐ No ☐ Not sure

Parent or carer address, if different from the child's address

Who does the child live with? Include relevant contact or care arrangements

Nursery or school: _____

Health visitor or school nurse, if known: _____

Is the child in foster care or looked after by a local authority?

☐ Yes ☐ No ☐ Not sure

Social worker or other professional involved, if applicable: _____

Contact details: _____

Any developmental concerns, additional needs or support we should know about?

For children and young people, we will discuss confidentiality and any access to records separately, taking account of their age, understanding and circumstances.

12 Vaccinations for all ages

Please provide any vaccination records you have, including vaccinations given overseas. For children, a copy of the relevant pages from the red book can help. Do not delay registration if records are unavailable.

Vaccinations and approximate dates, or attach a copy of your record



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13 Screening and pregnancy where relevant

Have you had cervical screening (a smear test)?

☐ Yes ☐ No ☐ Not sure ☐ Not applicable ☐ Prefer to discuss privately

Most recent date and result, if known: _____

Have you had a hysterectomy? ☐ Yes ☐ No ☐ Not applicable ☐ Prefer to discuss

If yes, was your cervix removed? ☐ Yes ☐ No ☐ Not sure

Are you currently pregnant? ☐ Yes ☐ No ☐ Not applicable ☐ Prefer to discuss

If yes, expected due date and maternity team, if known: _____

Any screening results or follow-up arrangements you would like us to know about?

Lifestyle and background

Patient name: _____ Date of birth: _____

These questions help us understand your health and support needs. Answer where relevant to your age and circumstances. You can leave a question blank or ask to discuss it privately.

14 Lifestyle

Height, if known: _____ (cm / ft and in) Weight: _____ (kg / st and lb)

What physical activity do you usually do, and how often?

Smoking: ☐ Never smoked ☐ Previously smoked ☐ Currently smoke

If current or previous smoker, type and amount per day: _____

If you stopped smoking, approximate date: _____

Do you vape or use other nicotine products? ☐ Yes ☐ No

Details: _____

Do you drink alcohol? ☐ Yes ☐ No ☐ Prefer to discuss privately

If yes, how often and approximately how much in a usual week?

Include the type, size and number of drinks, or units if you know them.

Would you like support with smoking, alcohol, drug use, diet or physical activity?

☐ Yes ☐ No ☐ Prefer to discuss privately



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15 Ethnic background

How would you describe your ethnic background? This helps us understand our patient population and plan care. Answering is optional.

Ethnic background

☐ Prefer not to say

16 Armed forces

Have you ever served in the UK armed forces, including as a reservist?

☐ Yes ☐ No ☐ Prefer not to say

If yes, service and discharge date, if applicable: _____

If available, please provide a copy of your service medical summary.

17 Other information

Anything else you would like us to know, including care plans or support needs?

☐ I would like to speak to a member of the team privately about a concern.



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Your information and declaration

Patient name: _____ Date of birth: _____

18 How we use your information

We use your personal and health information to register you, provide care and manage health services. Information may be shared with other organisations involved in your care, or where permitted or required by law. Ask reception for our privacy notice, which explains how we use and protect your information and your rights.

19 Summary Care Record

A Summary Care Record allows authorised health and care professionals involved in your care to see important information from your GP record, including medicines, allergies and adverse reactions. Additional information can include relevant medical history and communication needs.

Current NHS arrangements include additional information by default where you have not recorded a different preference. Existing choices to limit or opt out of a Summary Care Record continue to be respected.

You can choose a record with additional information, a record containing core information only, or no Summary Care Record. Ask us for information or the NHS patient preference form if you want to review or change your choice.

☐ I would like to discuss my Summary Care Record preferences.

Leaving this box blank is not a request to change an existing preference.

20 Someone helping with your care

You can ask us to arrange permission for a trusted person to discuss your care or access agreed online services. We will discuss what they can access and complete the relevant checks separately. This registration form does not grant access to your records.

☐ I would like information about permission to discuss care or online proxy access.

☐ There is a health and welfare attorney, court-appointed deputy or other formal arrangement we should know about. Please contact me to discuss the details.

21 Declaration

The information I have provided is accurate and complete to the best of my knowledge. I will tell the practice if my contact details or other relevant information changes.

Completed by: ☐ Patient ☐ Parent or carer ☐ Other representative

Name: _____

If not the patient, relationship and reason for completing the form: _____

Signature: _____ Date: _____

If you cannot sign, please ask reception for help.