

## Patient's details

Please complete in **BLOCK CAPITALS** and tick  as appropriate

<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms	Surname
Date of birth	First names
NHS No.	Previous surname/s
<input type="checkbox"/> Male <input type="checkbox"/> Female	Town and country of birth
Home address	
Postcode	Telephone number

## Please help us trace your previous medical records by providing the following information

Your previous address in UK	Name of previous doctor while at that address
	Address of previous doctor

## If you are from abroad

Your first UK address where registered with a GP

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If previously resident in UK, date of leaving	Date you first came to live in UK
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## If you are returning from the Armed Forces

Address before enlisting

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Service or Personnel number	Enlistment date
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## If you are registering a child under 5

I wish the child above to be registered with the doctor named overleaf for Child Health Surveillance

## If you need your doctor to dispense medicines and appliances\*

*\*Not all doctors are authorised to dispense medicines*

- I live more than 1 mile in a straight line from the nearest chemist
- I would have serious difficulty in getting them from a chemist

Signature of Patient     
  Signature on behalf of patient     
 Date

### NHS Organ Donor registration

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death. Please tick as appropriate

- Kidneys  
  Heart  
  Liver  
  Corneas  
  Lungs  
  Pancreas  
  Any part of my body

*Signature confirming consent to organ donation*

*Date*

For more information, please ask for the leaflet on joining the NHS Organ Donor Register

### NHS Blood Donor registration

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.

Tick here if you have given blood in the last 3 years

*Signature confirming consent to inclusion on the NHS Blood Donor Register*

*Date*

For more information, please ask for the leaflet on joining the NHS Blood Donor Register

My preferred address for donation is: (only if different from above, e.g. your place of work)

Postcode: .....

## To be completed by the doctor

Doctors Name

HA Code

- I have accepted this patient for general medical services  
 For the provision of contraceptive services  
 I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice

Doctors Name, if different from above

HA Code

- I am on the HA CHSlist and will provide Child Health Surveillance to this patient **or**  
 I have accepted this patient on behalf of the doctor named below, who is a member of this practice and is on the HA CHS list and will provide Child Health Surveillance to this patient.

Doctors Name, if different from above

HA Code

I will dispense medicines/appliances to this patient subject to Health Authority's Approval

I am claiming rural practice payment for this patient.  
 Distance in miles between my patient's home address and my main surgery is

*I declare to the best of my belief this information is correct and I claim the appropriate payment as set out in the Statement of Fees and Allowances. An audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission.*

Authorised Signature

Name

Date

Practice Stamp

# NEW PATIENT QUESTIONNAIRE

Please complete this form so we have some useful information about you before your old notes arrive and so that we can offer you services to help maintain your health. More Information about our services can be found in the Patient Handbook available at reception.

## 1. ABOUT YOU

(please circle the name you are usually known by)

Title ..... Name .....

Address:.....

..... Postcode: .....

Telephone: Home: ..... Work: ..... Mobile.....

Do we have your permission for us to leave a message with someone (or on the answering machine) at the above contact points?

**Home phone: YES / NO Work phone: YES / NO Mobile: YES / NO**

Date of birth: ..... Male  Female

Ethnic Origin: British..... Decline to answer .....

Other(please state origin.....

Main spoken language: English ..... Other:.....

Next of kin: ..... Tel:..... Relationship: .....

DO YOU HELP LOOK AFTER SOMEONE? Yes  No

(It need not be that they live with you or require constant care)

If yes please circle: Relative / Neighbour / Friend

## 2. ABOUT YOUR CURRENT HEALTH

Do you or have you ever smoked? Yes  Ex-smoker  Never

What is your height?.....What is your weight? .....

**3. FOR WOMEN ONLY**

**About cervical smears:**

Have you had a smear in the last 5 years    Yes                   No

**About contraception:**

What form are you using? .....

If you have a coil, when was it fitted?.....What type is it?.....

**Have you had a hysterectomy?**                                  Yes                   No

If yes, when? .....What was the reason?.....

**4. HEALTH CONDITIONS**

Have you ever been **diagnosed** with any of the following conditions? (please tick)

Diabetes	<input type="checkbox"/>	yr.....	Thyroid disease	<input type="checkbox"/>	yr.....
Stroke or transient ischaemic attack	<input type="checkbox"/>	yr.....	Cancer	<input type="checkbox"/>	yr.....
High blood pressure	<input type="checkbox"/>	yr.....	Heart disease	<input type="checkbox"/>	yr.....

Are you **taking medication** for any of the following?

Asthma	<input type="checkbox"/>	yr.....	Mental illness	<input type="checkbox"/>	yr.....
Other long term chest problem	<input type="checkbox"/>	yr.....	Epilepsy	<input type="checkbox"/>	yr.....

Are you taking any **other prescribed medication**? Yes                   No

If you have any other **health conditions** please give details: .....

.....

.....

.....

.....

**5. REACTIONS TO DRUGS AND ALLERGIES**

Have you had a reaction to any medication, or do you suffer from any allergies?

**If so please give details**.....

.....

.....

## 6. ALCOHOL INFORMATION

Alcohol Users Disorders Identification Test (AUDIT)						
Questions	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink that contains alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
	<b>Total</b>					
<b>If you scored a total of 5 &amp; above please answer the questions below</b>						
How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative/friend/doctor or health worker been concerned about you drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	
Scoring: 0-7 = sensible drinking, 8-9 = hazardous drinking, 16-19 = harmful drinking and 20+ = possible dependence						

**Please turn over**

Are you happy for health related personal information to be shared electronically with other health professionals involved in your care: YES / NO

**Sharing of relevant health information is vital to ensure good clinical care. Allowing your health information to be shared could be to your advantage (e.g. your allergy status if admitted to A&E). It is your right to prevent your health details to be accessed by health care professionals outside the practice. Confidentiality of records remains paramount and will be vigorously maintained.**

**Please sign here:..... Date.....**

**Thank you, now can we help you?**

- If you have **ticked** any of the boxes in **Section 4. Health Conditions** please make an appointment to see a **doctor** and bring your medication with you.
- If you would like help to give up **smoking** or to lose **weight** please make an appointment to see the **Practice Nurse**
- If you are **over 45**, or have a **family history** of high blood pressure or heart disease and have **not had your blood pressure recorded in the last 5 years**, or would like a health check, please make an appointment with a **Health Care Assistant**.
- If you are **house bound** and would like a health check please contact reception