



New Patient Questionnaire

<p>For reception use- Type of ID</p> <p>Catchment area postcode checked.</p> <p>Sign:</p>

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. Please show proof of name and address

PATIENT DETAILS:

(Please circle your preferred name)

Title.....Full Name.....

Previous Name.....

Date of Birth:/...../..... Age:

Gender: Male Female Other..... (Please specify)

NHS Number

Home Address.....

.....

Post Code.....

Telephone: Home.....

Work.....Mobile.....

Email Address.....

Do we have your permission for us to leave a message with someone (or on the answering machine) at the above contact points? YES / NO

Home Phone: YES / NO Work Phone: YES / NO Mobile: YES / NO

Town and country of birth.....

Nationality: Decline to answer

Main Spoken Language

Next of Kin: Name.....

Tel.....

Relationship.....

Are you a carer or do you help look after someone? YES / NO
(It need not be that they live with your or require constant care)

ABOUT YOUR CURRENT HEALTH:

Smoking status:

Never Smoked Ex-Smoker Date Ceased:/...../.....

Current Smoker How many per day.....

What is your height? What is your weight?

Do you have any problems with hearing? YES / NO

Are you visually impaired? YES / NO

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?

HEALTH CONDITIONS

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

Diabetes Thyroid disease Stroke or transient ischaemic attack Cancer

High blood pressure Heart disease Learning disability

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

Asthma Mental illness Epilepsy

Other long term chest problem

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

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

.....
.....
.....
.....

If you have ticked any of the above boxes please can you book a **double appointment** with a **doctor**.

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

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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	
	Total					
If you scored a total of 5 & above please answer the questions below						
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, 8-19 = harmful/hazardous drinking and 20+ = possible dependence						

THANK YOU – NOW CAN WE HELP YOU?

- If you have **ticked** any of the boxes in Section **Health Conditions** please make a **double** 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

If you have **internet access** you can book your appointment on line, order repeat prescriptions, and will be able to view your medication, allergies and vaccination history: This is available via our website – www.oakleyandovertonssurgery.co.uk

TO APPLY FOR OUR ON LINE SERVICES, PLEASE COMPLETE THE BOXES BELOW

I wish to have access to the following online services (please tick all that apply):

1. Booking appointments	<input type="checkbox"/>
2. Requesting repeat prescriptions	<input type="checkbox"/>
3. Accessing my summary care record (medications, allergies, adverse, reactions and vaccinations	<input type="checkbox"/>

For detailed coded access please contact reception who will ask you to complete a form.

By requesting access to the online services above I agree with the following statements

I will be responsible for the security of the information that I see or download. If I choose to share my information with anyone else, this is at my own risk. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement, and if I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible.

This Practice can prescribe electronically to any pharmacy of your choice, if you have previously nominated a pharmacy for your prescriptions to be sent to, this will be deleted from your records when we register you.

If you would like to nominate a local pharmacy please indicate below.

Overton Pharmacy Oakley Pharmacy

For other pharmacies please inform them when you collect your medication

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 to confirm you have read the attached ‘General Data Protection

Regulation’ leaflet :Date:/...../.....