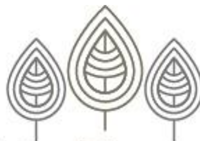
JUNE 2019



For reception - Type of ID:
Catchment area postcode checked:
Sign:

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.
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)

Religion: ……………………………………………………………… ..☐.Decline to answer

Nationality: …………………………………………………………………☐..Decline to answer

Main Spoken Language ……………………………………………………………………….

Do you require the help of a Translator/Interpreter? YES / NO

Telephone: Home……………………………………………………………………..

Work………………………………………Mobile…………………………………

Email Address………………………………………………………………………………

Do you give permission for us to leave a message with someone (or on the answering machine) at the above contact points? Home: YES / NO Work: YES / NO Mobile: YES / NO

Next of Kin: Name…………………………………………………………………………

Tel…………………………………………………………………......................................

Relationship………………………………………………………………………………

Do you give permission for your Next of Kin to discuss your clinical record on your behalf if needed? YES / NO

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)

If you have a carer/someone who looks after you, please state their name / address / phone number: ………………………………………………………………………………………

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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**? …………………………

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

....

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.**

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						**Overall Total:**

SPECIFIC NEEDS:

Do you have any sensory needs (i.e Speech / Sight / Hearing)

Are you an ‘Assistance Dog’ user? YES / NO

Please state any physical disabilities you have:…………………………………………………..

Please state any mental disabilities you have:……………………………………………………

Please state any requirements you have to be able to access our practice premises: …………

………………………………………………………………………………………………………..

Please state any phobias you have:………………………………………………………………...

Do you have any Relious or Cultural needs?...

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

Please sign here to confirm you have read the attached ‘General Data Protection

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

TO APPLY FOR OUR ONLINE SERVICES, PLEASE COMPLETE THE BOXES BELOW

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

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. Accessing my summary care record (medications, allergies, adverse, reactions and vaccinations	☐
4. Messaging Facility (sending electronic messages/request to the practice)	☐

For detailed coded access to your medical records please contact reception who will ask you to complete a separate 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.

Please state the Name of the local Pharmacy that you would like to nominate for your prescriptions to be sent to electronically:

…………………………………………………………………………………………………….

Signed:

Date: