

New Patient Questionnaire

WELCOME TO OUR PRACTICE

First Name		Last Name	
Address		Date of Birth	
Post code		Place of Birth	
Tel: Home		Tel: Mobile	
Marital Status		Main spoken language	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Occupation	
E-mail		Next of Kin Name	
Next of Kin Tel		Relationship	
Ethnic origin:	White British/Other white background/ White & Asian/Indian/Pakistani/ Other mixed/Other Asian background/ Caribbean/African/Chinese/ Other black background/Other/Refuse to disclose		

Do you consent to us contacting you by text and/or e-mail?

Yes by text and e-mail **Yes** by text only **Yes** by e-mail only **No**

Any email address and/or mobile number given for a person over the age of 14 years must be the person's own details and not those of their parent/guardian.






Under the Data Protection Act we have to inform you that the contents of any e-mails will not be confidential and secure. Any information we obtain from you will be used only for us to communicate with you. This information will not be passed on to any third party and will not be kept for longer than necessary. Confidentiality and security cannot be guaranteed whilst in transit and all e-mails should contain the minimum of identifiable information. Any e-mails you send will be stored on your e-mail provider's server and should be deleted as soon as possible as the NHS have no control over these mail servers.

Are you a Carer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes for whom?	
Are you being Cared for?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes by whom?	

If you are a Carer have you completed a yellow carer card to help us identify your needs? **Yes** **No**

Have you received information on the Summary Care Record? (SCR is where your basic medical history is shared with hospitals across England in case of an Emergency)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wish to opt out? (i.e. not let any information about you be available to hospitals, A&E or Out of Hours, if needed)	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you Smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No: Stopped (date): <input type="checkbox"/> Never	
If Yes - Cigarettes/Cigar/Pipe/E-Cigarette	How many a week?
Do you exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No (If YES , please give details)	

Do you drink Alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No		UNITS		    		
If YES: how many Units a week?						
Questions	0	1	2	3	4	Your score
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	7-8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Height :	Weight :
Have you got a recent Blood Pressure Readings? (If YES, please give details below)	
/ Date: (approx)	
Have you had any serious illness or operation in the past? Please give details:	
Do you take any regular medications? <input type="checkbox"/> Yes <input type="checkbox"/> No (If YES, please attach copy of your repeat prescription request form)	

Note: If you have nominated a specific pharmacy for your prescriptions you may need to change this to a more local pharmacy.

Do you have any allergies to any drugs, food or other substances? <input type="checkbox"/> Yes <input type="checkbox"/> No (If YES, please give details)
<input type="checkbox"/> I need to carry an adrenaline pen

Have you, your parents, siblings suffered with any of the following (and if so who and at what age)?

Asthma/COPD		Heart Attack/Heart Disease	
Mini Stroke/Stroke/TIA		Epilepsy	
High Blood Pressure		Diabetes	
Glaucoma		Cancer	
Kidney Disease		Depression/Mental Health problems	
Learning Difficulties		Thyroid problems	
Osteoporosis		Atrial Fibrillation	
Dementia		Other	

Are you currently under Hospital Care?	
Hospital Name	Consultant
Nature of Problem	
Vaccination History please tick if performed and give dates of most recent	
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Polio
<input type="checkbox"/> Tetanus	<input type="checkbox"/> Flu
<input type="checkbox"/> German Measles	<input type="checkbox"/> Any Other
Have you made an advance directive/living will? <input type="checkbox"/> Yes (please provide copy) <input type="checkbox"/> No	

WOMEN ONLY

When was your last cervical smear? Date: Result:	Are you in need of contraception? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you on HRT? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a ring pessary? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a Coil or Implant? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes when was it fitted?	

Special Needs

Detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action

Please state any Sensory Impairment you have (i.e. Speech, Hearing, Sight):
Are you an 'Assistance Dog' User?
Please state any Religious or Cultural needs:
Do you require the help of a Translator / Interpreter?

New patients or temporary registrations will **not be** accepted without proof of identification and proof of address. You will need bring 1 **PHOTOGRAPH ID AND 1 UTILITY BILL SHOWING CURRENT ADDRESS** to complete the registration process.

This information will only be used by doctors and staff of the Medical Centre and will be treated with confidentiality.

Name _____ Date _____

For office use only

Two forms of identity seen? 1]
2]

Checked by:
Please inform the patient of their named GP and record it here