New Patient Questionnaire

Personal Details

Name:……. D.O.B…….Male / Female

Do you know your NHS number?.....

Telephone number

Mobile number

Occupation:……..…

Ethnic Origin (very relevant in some illnesses & treatments)

……

Is English your first language? Yes/No
If No, what is your first language?.....

Medical History -This is a guide until we receive your medical records from your previous GP

Do you have any major health problems?

……

……

……

Have you had any operations in the past?

……

……

Are you currently seeing any hospital consultants?

……

……

Do you have any prescribed medication?

…… ……

…… ……

…… ……

Are you allergic to any medications?

……

……

General Health Please circle your answers

Your Alcohol consumption

Do you drink alcohol?

Yes	No*

(***If no* - proceed straight to next page)***

How often do you have a drink containing alcohol?

Never	Less than monthly	2-4 times a month	2-3 times a week	4 or more times a week

How many standard drinks containing alcohol do you have on a typical day when drinking?

1 or 2	3 or 4	5 or 6	7 -9	10 or more

MEN: How often do you have 8 or more drinks on one occasion?
WOMEN: How often do you have 6 or more drinks on one occasion?
(1 Drink = 1/2 pint of beer / 1 glass of wine / 1 single spirit)

Never *	Less than monthly	Monthly	Weekly	Daily or almost daily

(*If never please proceed straight to next page)

During the past year, how often have you found that you were not able to stop drinking once you've started?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily

During the past year, how often have you failed to do what was normally expected of you because of drinking?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily

During the past year, how often have you needed a drink in the morning to get yourself going after a heavy drinking session?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily

During the past year, how often have you had a feeling of guilt or remorse after drinking?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily

During the past year, have you been unable to remember what happened the night before because you had been drinking?

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 past year	Yes during the past year

Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?

No	Yes, but not in the past year	Yes during the past year

Would you like to talk to someone about your drinking habits? (If appropriate)

Yes	No

Smoking

Do you currently smoke? Yes No
If yes, how many cigarettes do you smoke?.....
Would you like help to stop smoking? Yes No

Have you smoked regularly in the past? Yes No
If yes, when did you stop smoking?.....

Family History: (blood relatives)

Heart attack No/Yes give details……Age of onset……

Diabetes No/Yes give details……Age of onset……..

Stroke No/Yes give details……Age of onset……

High Blood Pressure No/Yes give details……Age of onset……..

Cancer No/Yes give details……Age of onset……

Asthma No/Yes give details……Age of onset……

Kidney Disease No/Yes give details……Age of onset……

Any other condition No/Yes give details……Age of onset……

Are you a registered carer?if yes give details
……

……

****THIS QUESTION MUST BE ANSWERED** –** *Do you have a DOLS order in place?Are you a Veteran? Do you hold a living will? Are you on the sex offenders register or subject to MAPPA or SOPO?Not accept any blood products?*
Any other disclosure we would need to be aware of for your safety and ours?

YES / NO

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.....PTO

We offer all new patients either a long term illness annual health check, or a “well person” health check. Please book in at reception for your health check appointment.

Please tick below if you would like to register for our on-line services

- ☐ Prescription ordering / appointment booking service – once your registration form has been processed, would you like your login details sending via text or email?
  - ☐ Text
  - ☐ Email(please enter address)……

- ☐ Please tick to be part of our virtual patient participation group, to receive newsletters and information about the surgery by email
  Email(please enter address)……

Do you wish to opt out of our free text messaging service?

- Confirms and reminds you about future appointments
- Reminds you to make an appointment for your annual review / flu jab etc.
- Some pathology results can be relayed this way if you wish

☐Please tick this box if you **do not** want to receive any text messages from the surgery

Data sharing

Consultations from previous GP marked as private
Please note, this practice operates an electronic transfer of your medical history, (GP2GP) if you have any prior consultations that were previously marked as private, they will now be visible in your record. If you wish to do so, please make an appointment with the practice manager to have them reinstated as private consultations.

Summary Care Record (SCR)
This surgery automatically uploads information from the patient record to the Summary Care Record.The SCR is intended to provide a summary of individual patient information to the clinicians who may provide treatment in areas of care remotely from the GP practice, for example A & E, an out of hours centre or an acute admissions unit. The information currently uploaded is.

- Current medicines
- Allergies and adverse reactions to drugs that can make you ill.

Please ask at reception for an opt-out form if you have chosen not to have a SCR created.

Signed by patient…….date……..