|  |  |
| --- | --- |
| **.Received By:** |  |
| **Date:** |  |

**New Patient Questionnaire**

**Dear Patient,**

This set of questions has been designed to help us to get to know you and your medical problems. **Please fill in the entire form or there could be delays in your registration.** All the information gathered from these questions will be handled confidentially. Your named accountable GP will be **Dr V Rai or Dr K Ahmed**.

**Surname**: ……………………………………….……… **Forenames**: ………………………………..………………………………. **Sex: M/F**

**Address**: …………………………………………………………………………..…………………………………………………………..……………

**Post Code**: ………………………………………… **Tel No**: ………………………………………

**Email address:** …………..……………………………………………………………………………

Your Preferred Method of Contact (please circle): SMS / Telephone / Letter / Email

*This is how the surgery will contact you unless in an emergency*

**DOB**: ………………………….. **Country of Birth**: ……………………………………………….……… **Marital Status**: ……..………….

**Children**: Male ………… Female ………..…… **Occupation** (past & present) …………………..………………………….

**Place of Birth**……………………………………………………….

**Have you been a member of the Armed Forces** ………………………………………………………………………………………………

**Housing**: …………………………………….……….

**Next of Kin:** …………………………………………………… **Relationship**: ………………………….……………

**Tel No:** …………………………………………………………… **Address:** ………………………………………………………………………………………………

**ETHNICITY Interpreter Needed: YES/NO If YES, language** ……..………………..……………………………….……………

|  |  |  |  |
| --- | --- | --- | --- |
| White British  | Indian  | Black Caribbean  | Any Mixed Background  |
| Other White British  | Pakistani  | Black African  | Other Ethnic Group  |
| White Irish  | Chinese  | Black British  | Other  |
| White European  | Other Asian  | Other Black  | Patient Declined  |
| **Main Spoken Language** |

**HEIGHT & WEIGHT**

Do you know your Height …………………………..……… & Weight ………………………………………………

At this surgery we offer weight management advice. Would you in interested in speaking to our clinician for weight management advice? **YES / NO**

**PRESENT ILLNESSES/TREATMENTS**

Please list all illnesses you are receiving hospital treatment for:

*
*
*
*

**PRESENT MEDICINES (Prescribed)**

Please provide a printed list from your previous practice of any medicines or tablets you are taking at present and the illness for which you are taking them. If you require repeat medication, please provide us with either the last computer tear-off slip, showing the medication prescribed or the original containers showing the relevant information.

**If you do not have a printed list, please give details of any medication you take (prescribed or otherwise):**

**MEDICATION**

Name of drug: …………………………………………………………………………………………………………….

Dosage: ……………………………………………………………………………………………………………………..

Name of drug: …………………………………………………………………………………………………………….

Dosage: ……………………………………………………………………………………………………………………..

Name of drug: ………………………………………….……………………………………………………………….…

Dosage: ……………………………………………………………………………………………………………………..

**ALLERGIES & Disabilities:**

Are you allergic or sensitive to any medicines, food, animals, etc.?

**Do you have a disability?** [ ]  Yes [ ]  No If yes please state \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you class your disability as  **Slight** [ ]  **Moderate** [ ]  **Severe** [ ]

(*Please note the answer to the above may have an impact on any future life insurance policy or private health insurance premiums*)

Do you have any communication difficulties that may require any additional assistance?

(for example: sensory loss, language barrier etc.)

**Please Note:**

**CARERS**

Do you need / have anyone who looks after you or your daily needs? **Yes / No**

If “Yes”, would you like them to deal with your health affairs here? **Yes / No**

(the receptionist can help with these arrangements)

What is the name and contact details of your carer? ……………………………….…………………………………………………..

Do you care for anyone else? **Yes / No**

If “Yes”, ask the receptionist about Carers support

What is the name of the person being cared for: ……………………………………………………..

**FAMILY HISTORY**

Does any of your family have any of the following illnesses or conditions:-

|  |  |  |
| --- | --- | --- |
| **CONDITION** | **YES OR NO** | **WHO HAS/HAD THE CONDITION & AT WHAT AGE** |
| High Blood pressure |  |  |
| Heart Attack |  |  |
| Stroke |  |  |
| Angina |  |  |
| Asthma |  |  |
| Eczema |  |  |
| Any Hereditary Diseases i.e. Cystic Fibrosis, Huntington’s etc. |  |  |
| Diabetes |  |  |
| Breast or Bowel Cancer |  |  |
| Any other illness or condition |  |  |

**SMOKING:**

Have you ever smoked? **YES 🞎 / NO 🞎**

Are you a current smoker? **YES 🞎 / NO 🞎**

**If YES:** Would you like to stop smoking?**: YES 🞎 / NO 🞎**

Cigarettes per day …………. Cigars per day ..……….. Ounces of tobacco per day …………...

Are you at risk of exposure to tobacco smoke? **YES 🞎 / NO 🞎**

**DRUG USE:**

Have you ever used illicit drugs? **YES 🞎 / NO 🞎**

**If Yes**, are you currently using any illicit substances? **YES 🞎 / NO 🞎**

**MEMORY:**

Have you ever had concerns about your memory? **YES 🞎 / NO 🞎**

**FEMALE PATIENTS ONLY**

Date of most recent cervical smear: …………..…………….Where was this done: ………………………………………….……………

Results of most recent smear: ………………………………………………………………………

**Please Note: If you do not wish to have a cervical smear please ask to sign a disclaimer which will deduct you from our recall list for 5 years**

Do you use contraceptives (please tick):

 The pill

 Intra-Uterine Coil

 Diaphragm

 Sheath

 Other Methods

 Sterilized/partner had vasectomy

 Not applicable

*Please use the below chart to help you with the next part of the questionnaire:*



**Alcohol use disorders identification test (AUDIT)**

AUDIT is a comprehensive 10 question alcohol harm screening tool. It was developed by the World Health Organisation (WHO) and modified for use in the UK and has been used in a variety of health and social care settings.

|  |  |  |
| --- | --- | --- |
| Questions | Scoring System | Your Score |
| 0 | 1 | 2 | 3 | 4 |
| How often do you have a drink containing alcohol? | Never | Monthly or less | 2 to 4 times per month | 2 to 3 times per week | 4 times or more per week |  |
| How many units of alcohol do you drink of a typical day when you are drinking? | 0 to 2 | 3 to 4 | 5 to 6 | 7 to 9 | 10 or more |  |
| How often have you had 6 or more units if female, or 8 or more units if male, on a single occasion in the last year? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you found that you were not able to stop drinking once you had started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you failed to do what was normally expected from you because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking sessions? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you had a feeling of guilt or remorse after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last 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 somebody 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 or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down? | No |  | Yes, but not in the last year |  | Yes, during the last year |  |
| Total AUDIT score |  |

Would you like drink management advice? YES / NO

**Patient Data Consent Form**

Please read the following carefully as it will give you information about how we protect, use and share, your electronic and paper-based health record.

1. **How we protect your information within the Legislative Framework**

The purpose for which we hold and process both personal and medical data is to assist the Practice in the provision and administration of patient care. As guardian of this information, we endeavour to follow a code of conduct which encompasses ‘The Access to Medical Records Act 1990’, ‘The Freedom of Information Act 2000’, ‘The Data Protection Act 1998’, ‘The Common Law Duty of Confidentiality’ and adhere to the NHS Code of Practice when sharing information between health professionals in support of patient care. We will **not** share or disclose your information with other 3rd parties (outside of the said purpose), unless we have your signed consent to do so.

We ask that you consent to the information that is recorded about you, being made available to other NHS care services that care for you now and in the future for e.g. Secondary Care Services, District Nursing Services, Community Services etc.

**Please tick box to note consent:**

1. **Summary Care Record – your emergency care summary**

The NHS introduced the Summary Care Record, to ensure that those caring for you in an emergency situation have enough information to treat you safely. The Summary Record contains information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had.

**Please tick box to note consent**

Further information can be accessed from the follow links:

[www.nhs**carerecords**.nhs.uk](http://www.nhscarerecords.nhs.uk)

[www.legislation.gov.uk](http://www.legislation.gov.uk)

**Please let us know if you do not want a Summary Care Record or to share your information with other NHS Services and we will provide you with an opt-out form.**

1. **Messages to patient’s via Text (SMS) and Email**

The practice offers SMS Text messaging service to your mobile phone. We use this service in several ways:

* To remind patients about their appointments
* To ask them to contact the practice
* To inform them on current health screening opportunities and in some cases about test results etc

(None of these messages will contain your name)

Due to the personal content of these messages, it is very important that you keep the Practice informed of any changes to your mobile phone number or email address.

 (Please note that the NHS mail messaging service utilises the public telephone network and as such full security is not guaranteed)

**Please tick box to note consent**

1. **Medical Photography Consent**

To help practice staff identify you in person, we ask that you give consent for a ‘Face Only’ photograph to be taken and included on the front screen of our electronic medical record. Additionally, there may be occasions when a clinician requires a medical image to review and compare particular skin lesions. We therefore ask that you give consent for both ‘Face Only’ identification photography & medical imaging for medical purposes only.

**Please tick box to note consent**

**Patient’s Signature**

I ………………………………………………………………… (Patients Name)

Give my consent for IH Medical to hold and process my personal data as noted above in the Patient Data Consent Form

**Signature**………………………………………………………………………. **Date**……………………………………….

***PLEASE PROVIDE ID TO REGISTER FOR THIS SERVICE***

**Patient Online: Registration form**

**Access to GP online services – Over 18’s Only**

|  |  |
| --- | --- |
| Surname |  |
| First Name |  |
| Date of Birth |  |
| Address |  |
| Postcode |  |
| Email Address |  |
| Telephone Number |  | Mobile Number |  |

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

|  |  |  |
| --- | --- | --- |
| 1. | Booking appointments |  |
| 2. | Requesting repeat prescriptions |  |
| 3. | Accessing my medical record |  |

 **Application for online access to my medical record**

 I wish to access my medical record online and understand and agree with each statement (please tick)

|  |  |  |
| --- | --- | --- |
| 1. | I have read and understand the information leaflet provided by the practice |  |
| 2. | I will be responsible for the security of the information I see or download |  |
| 3. | If I choose to share my information with anyone else, this is at my own risk |  |
| 4. | I will contact the practice as soon as possible if I suspect that my account has been accessed by someone else without my agreement |  |
| 5. | If I see information in my record that is not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Signature |  | Date |  |