New Patient Questionnaire.

Please complete as many questions as you can. The information will help the practice to provide better medical care for you.

Date…….. Surname ……. Sex Male / female

Forename ……. Occupation …….....

Date of Birth ……. Marital Status ……..

Address ……. Tel No/Nos: ……..

……. Tel No Relative …….....

Email address …….

Do you consent to being contacted by: **Text Message** Yes / No **Email** Yes/No

Ethnic Origin ……. My First Language is: ……..……

Are you a carer? Yes / No Name of person you care for: ……..

Personal Medical History
Please list serious operations, disabilities.

Date……operation/disability……..…. Date……operation/disability …….....

Date……operation/disability……..…… Date……operation/disability …….....

Have you ever suffered from:

Epilepsy Yes / No Diabetes Yes / No Blood pressure Yes / No
Blindness/Glaucoma Yes / No Strokes Yes / No Heart attacks Yes / No
Do you have difficulty hearing, or need hearing aids or need to lip-read what people say? Yes / No
Do you have difficulty with memory or ability to concentrate, learn or understand Yes / No
Do you have difficulty speaking or using language to communicate or make your needs known? Yes / No

Medical History of Family (Brothers, sister, parents, uncles/aunts) Has any close relative suffered from:

Epilepsy Yes / No Asthma Yes / No Diabetes Yes / No
Blood Pressure Yes / No Strokes Yes / No
Heart Attacks Yes / No Cancer Yes / No

Do you smoke ? Yes / No How many cigs a day …….. When did you stop……..

Height …… Weight …….

Drugs and Medicines.

Are you taking any drugs, medicines, tablets or contraceptive treatment? Yes / No
If you take regular medication please supply us with the repeat order form from your previous surgery if possible.

Are you allergic to any tablets or substances? Yes / No If yes, which ones……

Would you like to nominate a pharmacy for your repeat prescriptions to be sent to?

Name of pharmacy …….

Women.

Have you had a hysterectomy Yes / No When ……
Date of last smear ……..

If you would like a New Patient Check, please book an appointment at reception.

Name ……. DOB……..

Alcohol Questionnaire

For the following questions please score the answer, which best applies. (1 drink= ½ pint beer or 1 glass of wine or 1 single spirits)

Score	**0**	**1**	**2**	**3**	**4**	**Enter Score**
How often did you have a drink containing alcohol in the past year	Never	Monthly Or less	2 – 4 times a month	2-3 times a week	4 or more times a week	
How many drinks containing alcohol did you have on a typical day when you are drinking in the past year	1 or 2	3 or 4	5 or 6	7 or 9	10 or more	
How often did you have six or more drinks on one occasion in the past year?	Never	Monthly Or less	Monthly	Monthly	Daily or almost daily	

ALL INFORMATION WILL BE HELD ELECTRONICALLY IN THE PRACTICE. THANK YOU FOR YOUR HELP.

Summary Care Records (SCR)

The SCR is an electronic record of important patient information, created from GP medical records. It can be seen and used by authorised staff in other areas of the health and care system involved in the patient's direct care.

If you Opt Out NHS Healthcare staff caring for you may not be aware of your current medication, allergies you suffer from and any bad reactions you have had, in order to treat you safely in an emergency.

Do you consent to SCR YES/No (If No – please ask reception for a Decline SCR form)

ON-LINE SERVICES

Either: Complete the attached ON-LINE application form
OR: to be able to book/cancel/view Appointments only, visit https://www.patientaccess.com/ and complete the registration form.