Date:…….

New Patient Questionnaire.

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

Title: ……. Forename: …….. Surname: …… Sex: Male ☐ Female ☐

Date of Birth ……. Marital Status: ……. Occupation: ……

Address ……. Postcode: ……

……. Tel No/Nos: ……..

Email Address: ……..

Tel No NOK: ……..... Relationship: ……

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

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

Do you require a translator? 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 ☐

Do you require information in a specific format (e.g. braille)? ……..……..……
Are there any other reasonable adjustments required for health and care access as per the equality act 2010? (Please detail below)

……..……..……..……..

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 ☐

Drugs and Medicines.

Please nominate a pharmacy for us to send any prescriptions you may need.

Name of pharmacy ……

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……

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

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

Height …… **Weight** ……

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	

Veterans

Are you a military veteran? Yes ☐ No ☐

What field did you serve in? ……

……..……..……..……..

Women Only.

Have you had a hysterectomy Yes ☐ No ☐ When ……

Date of last smear ……..

Self-Service POD

In reception, we have a Self-Service POD which can be used by patients to record their: Blood Pressure, Height, Weight, Alcohol Consumption (Audit-C), Smoking Status, Activity (exercise), Anxiety Levels, Contraceptive Check (Pill Check) and Asthma Reviews. Slots are available to use the POD weekdays between 08:30 and 18:00.

ON-LINE SERVICES

Ask reception for an EMIS online access form. Once completed, we can can grant you access to see your Appointments, Medications, Test Results, Immunisations, Medical Problems and Consultation.

If you are applying for on-line services, you must provide proof of address (e.g. utility bill in the last three months) and photo ID

ALL INFORMATION WILL BE HELD ELECTRONICALLY IN THE PRACTICE.

THANK YOU FOR YOUR HELP.

Date Created 05/05/2023