**Dovercourt Surgery**

**NEW PATIENT QUESTIONNAIRE**

PLEASE BE AWARE THAT WE NEED PHOTO ID AND A RECENT UTILITY BILL OR LETTER WITH YOUR CURRENT ADDRESS ON

Please provide your NHS number on the purple form thanks

|  |  |
| --- | --- |
| **SURNAME** |  |
|  |  |  |  |  |  |
| **FORENAME** |  |
|  |  |  |  |  |  |
| **MALE / FEMALE** |  |
|  |  |  |  |  |  |
| **ADDRESS** |  |
|  |  |  |  |  |  |
| **CONTACT TELEPHONE NUMBER** |  |
|  |  |  |  |  |  |
| **DATE OF BIRTH** |  | **PLACE OF BIRTH** |  |
|  |  |  |  |  |  |
| **ETHNICITY (PLEASE TICK)** |
|  |  |  |  |
|  | WHITE BRITISH |  | BLACK AFRICAN, NON MIXED ORIGIN |
|  |  |  |  |
|  | WHITE IRISH |  | INDIAN |
|  |  |  |  |
|  | WHITE, OTHER |  | PAKISTANI |
|  |  |  |  |
|  | BLACK CARIBBEAN |  | BANGLADESHI |
|  |  |  |  |
|  | BLACK CARIBBEAN AND WHITE |  | CHINESE |
|  |  |  |  |
|  | BLACK AFRICAN |  | GYPSY/ ROMANY |
|  |  |  |  |
|  | ROMA SLOVAK |  | ETHNIC GROUP, OTHER |
|  |  |  |  |
|  | OTHER ETHNIC, OTHER MIXED ORIGIN |
|  |  |  |  |
|  | ETHNIC GROUP NOT GIVEN (PATIENT REFUSED) |
|  |  |  |  |  |
| **MAIN SPOKEN LANGUAGE** |  |
|  |  |  |  |  |
| **DO YOU NEED AN INTERPRETER?** | YES | NO |
|  |  |  |  |  |
| **Do you have any information or communication needs that we need to be aware of?** |
|  |
|  |
|  |
| **DO YOU HAVE ANY SOCIAL CIRCUMSTANCES THAT WE NEED TO BE AWARE OF?** |
|  |
|  |
|  |
|  |  |  |  |  |
| **WHAT REGULAR MEDICATION ARE YOU CURRENTLY TAKING?** |
|  |
|  |
|  |  |  |
| **ARE YOU ALLERGIC TO ANY MEDICATION?** | YES | NO |
|  |
| **IF SO, WHAT ARE YOU ALLERGIC TO?** |  |
|  |
| **WHAT KIND OF REACTION DID YOU HAVE?** |  |
|  |
| **WHEN DID THIS OCCUR?** |  |
|  |
| **HAVE YOU BEEN IN HOSPITAL IN THE LAST 12 MONTHS?** |
|  |
| YES | NO |
|  |
| **Please state the hospital you attended and the reason why** |
|  |
|  |
|  |
| **DO YOU SUFFER FROM OR HAVE HAD ANY OF THE FOLLOWING CONDITIONS? PLEASE STATE THE DATE YOU WERE DIAGNOSED** |
|  |
| DEPRESSION | **YES** / **NO** |  | Date |  |
|  |
| ASTHMA | **YES** / **NO** |  | Date |  |
|  |
| DIABETES | **YES** / **NO** |  | Date |  |
|  |
| BLOOD PRESSURE | **YES** / **NO** |  | Date |  |
|  |
| HEART PROBLEMS | **YES** / **NO** |  | Date |  |
|  |
| STROKE | **YES** / **NO** |  | Date |  |
|  |
| **Please state any other illnesses that you suffer from or have had** |
|  |
|  |
|  |
| **DO YOU HAVE ANY FAMILY HISTORY OF DISEASE; FOR EXAMPLE, HEART DISEASE, ARTHRITIS ETC?** |
|  |
|  |
|  |
| **WHEN DID YOU LAST HAVE A TETANUS INJECTION?** |  |
|  |
| **WOULD YOU LIKE A HEALTH CHECK WITH A PRACTICE NURSE?** |
|  |
| YES | NO |

**CAN YOU PROVIDE US WITH YOUR NEXT OF KIN DETAILS?**

|  |  |
| --- | --- |
| **SURNAME** |  |
|  |  |  |  |  |  |
| **FORENAME** |  |
|  |  |  |  |  |  |
| **MALE / FEMALE** |  |
|  |  |  |  |  |  |
| **ADDRESS** |  |
|  |  |  |  |  |  |
| **CONTACT TELEPHONE NUMBER** |  |

|  |  |
| --- | --- |
| **HOW IS THIS PERSON RELATED TO YOU ?** |  |

|  |
| --- |
|  |
|  |

**SMOKING SURVEY**

WE ARE UPDATING OUR RECORDS AND WOULD APPRECIATE IF YOU COULD TAKE A FEW MOMENTS TO COMPLETE THE FOLLOWING SURVEY

|  |  |
| --- | --- |
| **NAME** |  |
|  |
| **DATE OF BIRTH** |  |
|  |
| PLEASE CIRCLE AS APPROPRIATE |
|  |
| **DO YOU SMOKE?** | YES | NO |
|  |
| **IF YES, HOW MANY DO YOU SMOKE?** |  |
|  |
| **IF YES, WHAT DO YOU SMOKE?** |
|  |
| CIGARETTES | CIGARS | PIPE |
|  |
| **HAVE YOU EVER SMOKED?** | YES | NO |
|  |
| **IF YES, HOW MANY DID YOU SMOKE?** |  |
|  |
| **IF YES, WHEN DID YOU GIVE UP SMOKING?** |  |
|  |
| **IF YES, WHAT DID YOU SMOKE?** |
|  |
| CIGARETTES | CIGARS | PIPE |
|  |
| **WOULD YOU LIKE ANY HELP OR ADVICE TO STOP SMOKING?** |
|  |
| YES | NO |
|  |
| **IF YES, WHAT TYPE OF HELP WOULD YOU LIKE TO RECEIVE?** |
|  |
| DETAILED BOOKLET |  |
|  |
| ONE-TO-ONE APPOINTMENT WITH A NURSE |
|  |
| STOP SMOKING GROUP |

**ARMED FORCES**

ARE YOU CURENTLY SERVING OR HAVE YOU EVER SERVED IN THE ARMED FORCES?

|  |  |
| --- | --- |
| YES | NO |

|  |
| --- |
|  |

**CARER INFORMATION**

WE ARE INTERESTED IN IDENTIFYING CARER’S, ESPECIALLY THOSE PEOPLE WHO MAY BE CARING WITHOUT HELP OR SUPPORT

|  |
| --- |
| **DO YOU LOOK AFTER SOMEONE WHO IS ILL, FRAIL OR DISABLED?** |
|  |
| YES | NO |
|  |  |
| **DOES SOMEONE LOOK AFTER YOU?** | YES | NO |
|  |  |
| **CAN YOU PLEASE PROVIDE US WITH THEIR DETAILS?** |
|  |
| CARER’S NAME |  |
|  |  |
| CARER’S ADDRESSS |  |
|  |  |
| CARER’S CONTACT NUMBER |  |
|  |  |
| **DO YOU/ THEY WANT ANY INFORMATION ON THE SHEFFIELD CARERS CENTRE?** |
|  |  |
| YES | NO |

|  |
| --- |
|  |
|  |

**WOMEN ONLY**

|  |  |
| --- | --- |
| **PLEASE STATE THE DATE OF YOUR LAST SMEAR** |  |
|  |
| **DO YOU TAKE THE CONTRACEPTIVE PILL OR DEPOT INJECTION?** |
|  |
| YES | NO |

**This is one unit of alcohol…**

****

**…and each of these is more than one unit**

****

**AUDIT – C**

|  |  |  |
| --- | --- | --- |
| **Questions** | **Scoring system** | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink containing alcohol? | Never | Monthlyor less | 2 - 4 times per month | 2 - 3 times per week | 4+ times per week |  |
| How many units of alcohol do you drink on a typical day when you are drinking? | 1 -2 | 3 - 4 | 5 - 6 | 7 - 9 | 10+ |  |
| How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |

**Scoring:**

**SCORE**

A total of 5+ indicates increasing or higher risk drinking.

An overall total score of 5 or above is AUDIT-C positive.

**If your score is 5 or more pleas complete the questions on the reverse of the form**

**Score from AUDIT- C (other side)**

**SCORE**

**Remaining AUDIT questions**

|  |  |  |
| --- | --- | --- |
| **Questions** | **Scoring system** | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| 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 session? | 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 |  |

**Scoring:** 0 – 7 Lower risk, 8 – 15 Increasing risk,

**TOTAL = =**

 16 – 19 Higher risk, 20+ Possible dependence

TOTAL Score equals

AUDIT C Score (above) +

Score of remaining questions

 

***Your Electronic Patient Record & the Sharing of Information***

***- A Patient’s Guide***

***Please read this leaflet carefully. It will give you information about the sharing of your electronic patient record and the choices you need to make***

Today, electronic records are kept in all the places where you receive healthcare. These NHS Care Services can usually only share information from your records by letter email, fax or phone. At times, this can slow down your treatment and mean information is hard to access.

Your GP practice uses a computer system called SystmOne that allows the sharing of full electronic records across different NHS Care Services. We are telling you about this as a patient at this practice as you have a choice to make about how your practice shares information about your care from your electronic patient record. This form is not about your Summary Care Record (SCR), it is asking your sharing preferences regarding your full electronic GP record. You can choose to share or not to share your electronic GP record with other NHS Care Services.

**How is my decision recorded?**

Your GPs computer system has two settings to allow you to control how your medical information is shared:

**Sharing Out** – This controls whether your full GP electronic patient record can be shared with other NHS Care Services where you are treated. Please record your preference:

**Please tick:** Sharing Out **Yes** (shared) □ or **No** (not shared) □

**Sharing In** – This controls whether you agree for this practice to view information you’ve agreed to share at other NHS Care Services. Please record your preference:

**Please tick:** Sharing In **Yes** (viewable) □ or **No** (not viewable) □

Patient Name (Print Name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_