Dove River Practice - New Patient Questionnaire

Name			
Date of Birth		Occupation	
Do you consent to text messaging	Yes ☐ No ☐	Do you consent to contact via email	Yes ☐ No ☐
Email address			

Height		Weight	
How many units of alcohol do you drink per week:			
Non smoker ☐ Smoker ☐			
If a smoker how many do you smoke per day:			

Previous Illnesses / Operations
Eg: diabetes, heart attack, stroke, asthma, high blood pressure
(continue over if necessary)

Are you taking any medicines or tablets (please list)

Any Disabilities	
Allergies	
Date of last Tetanus	

Females

Date of last smear		**No of children**		**Ages**	

Family history – Have any of your close family had any of the following before they were 60 yrs old? (Please give brief details)	
Diabetes	
Heart Attack	
Stroke	
Asthma	
High Blood Pressure	
Cancer	

P.T.O

PATIENT ETHNIC ORIGIN FORM

This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act.

Please indicate your ethnic origin below. This is not compulsory, but may help with your healthcare as some health problems are more common in specific communities, and knowing your origins may help with early identification of some of these conditions.

White: English or Welsh or Scottish or Northern Irish or British	
White: Irish	
White: Gypsy or Irish traveller	
White: any other White background	
Asian or Asian British: Indian	
Asian or Asian British: Chinese	
Asian or Asian British: Pakistani	
Asian or Asian British: Bangladeshi	
Asian or Asian British: any other Asian background	
Black or African or Caribbean or Black British: African	
Black or African or Caribbean or Black British: Caribbean	
Mixed multiple ethnic groups: White and Asian	
Mixed multiple ethnic groups: White and Black African	
Mixed multiple ethnic groups: White and Black Caribbean	
Other ethnic group: Arab	
Other ethnic group: any other ethnic group	
Refusal to provide information about ethnic group	

Signature		Date	

AUDIT-C QUESTIONNAIRE

Name: Date completed:

DOB:

Pint of Regular Beer/Lager/Cider 2 units	Alcopop or can of lager 1.5 units	Glass of wine 2 units	Single measure of spirits 1 unit	Bottle of wine 9 units

For the following questions please tick the answer which best applies

1. How often did you have a drink containing alcohol in the past year?	**Never** ☐ 0	**Monthly or Less** ☐ 1	**Two to four times a month** ☐ 2	**Two to three times per week** ☐ 3	**Four or more times a week** ☐ 4
2. How many drinks did you have on a typical day when you were drinking in the past year?	**1 or 2** ☐ 0	**3 or 4** ☐ 1	**5 or 6** ☐ 2	**7 or 9** ☐ 3	**10 +** ☐ 4
3. How often did you have six or more drinks on one occasion in the past year?	**Never** ☐ 0	**Monthly or Less** ☐ 1	**Monthly** ☐ 2	**Weekly** ☐ 3	**Daily or almost Daily** ☐ 4
Total for Each Column:					
Total Score (A) : _____ #38D4					

IF YOU HAVE SCORED 5 OR MORE, PLEASE COMPLETE THE FULL ALCOHOL QUESTIONNAIRE ON THE NEXT PAGE

FULL Alcohol Questionnaire

Name: Date completed:

DOB:

Pint of Regular Beer/Lager/Cider 2 units	Alcopop or can of lager 1.5 units	Glass of wine 2 units	Single measure of spirits 1 unit	Bottle of wine 9 units

Questions	**0**	**1**	**2**	**3**	**4**	**Your Score**
How often in the last year have you been unable to stop drinking once you had started?	Never ☐ 0	Less than monthly ☐ 1	Monthly ☐ 2	Weekly ☐ 3	Daily or almost daily ☐ 4	
How often I the last year have failed to do what was expected of you because of drinking?	Never ☐ 0	Less than monthly ☐ 1	Monthly ☐ 2	Weekly ☐ 3	Daily or almost daily ☐ 4	
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never ☐ 0	Less than monthly ☐ 1	Monthly ☐ 2	Weekly ☐ 3	Daily or almost daily ☐ 4	
How often in the last year have you had a feeling of guilt or regret after drinking?	Never ☐ 0	Less than monthly ☐ 1	Monthly ☐ 2	Weekly ☐ 3	Daily or almost daily ☐ 4	
How often in the last year have you not been able to remember what happened when drinking the night before?	Never ☐ 0	Less than monthly ☐ 1	Monthly ☐ 2	Weekly ☐ 3	Daily or almost daily ☐ 4	
Have you or someone else been injured as a result of drinking?	No ☐0		Yes, but not in the last year ☐ 2		Yes, during the last year ☐ 4	
Has a relative/friend/doctor/ health worker been concerned about your drinking or advised you to cut down?	No ☐0		Yes, but not in the last year ☐ 2		Yes, during the last year ☐ 4	
					Total Score (B)	

For office use only	*Score A* *+* *Score B* ___________ */ 40 #38D3*

Patient Information Leaflet
Accessing Patient Online Services

GP Practices are contractually required to offer access to Online Services, which we have been doing since 2015.
You can access your online health record via the NHS App or NHS online login. This can show you recent interactions with the surgery. You can also request repeat medications and book appointments.

Please note:

- **It is your responsibility to keep login details and passwords safe. If you suspect your account has been accessed by someone without your consent you should change this password immediately. If you cannot do this, we recommend you contact the practice to suspend your online access until you can reset the password.**
- **If you print out any information from your record, it is your responsibility to keep this secure. If you cannot do this, we recommend you do not make any printouts**
- **The practice will not approve online access if it is deemed this may cause physical and/or mental harm to the patient. The practice has the right to remove online access to services for anyone that does not use them responsibly**
- **For more information on keeping you records safe and secure, a helpful leaflet is available http://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Documents/PatientGuidanceBooklet.pdf**

Points to consider when accessing your medical record online

Choosing to share your information with someone or consenting to Proxy access
It is your choice whether or not to share information with others. It is also your responsibility to keep your information safe and secure.

Coercion
If you are worried that you may be put under pressure to reveal details from your patient record to someone against your will, we would suggest that you do not register to access this service

Contents of your medical record
Your medical record may contain information that is historical and possibly forgotten. It may contain information not relevant to yourself or abnormal test results/bad news. You may find some of this information upsetting. If you do identify information not relevant to yourself, please contact the surgery as soon as possible so that we can take appropriate action.
Also, the records are written using terminology designed to be understood by clinical professionals. You may find this difficult to understand.

Information about someone else
If you find something in your record that does not relate to you or you find any other errors, please contact the practice as soon as possible