**New Patient Questionnaire**

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| **Full Name:** | **DOB:** |
| **Home number:** | **Mobile number:** |
| **Work number:** | **E-mail address:** |
| **Do you give consent for us to contact you via text message?** YES NO  *Please be aware if you say “NO” you* ***will not*** *receive appointment reminders via text* | |

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| **Marital Status:** (Please circle) | Common Law Partnership | Divorced | Married |
| Separated | Widowed | Single |
| **Your Occupation:** | | | |

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| **What would you consider your Ethnicity to be?** (Please circle) | | | | | | | |
| English | Welsh | | Scottish | | | Northern Irish | Irish |
| Gypsy/Irish Traveller | White and Black Caribbean | | White and Black African | | | White and Asian | Chinese |
| Indian | Pakistani | | Bangladeshi | | | African | Caribbean |
| Other White background | Other Asian/Multiple Asian background | | Other Black/African/Caribbean multiple background | | | Other mixed multiple background | |
| **Are you an English Speaker?** | YES | | NO | | | **First Language spoken:** | |
| **Do you need an interpreter?** | | | | | | | |
| **Do you have any specific communication needs?** *Please tick* | | | | | | | |
| □ Blind | | □ Partially sighted | | □ Deaf | □ Hearing Impaired | | |
| □ Memory problems | | □ Learning disability | | □ Autism | Please specify other: | | |
| **If you ticked one of the above**, how should we contact you? (If you would like us to contact you via another person please provide their details.) | | | | | | | |

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| **Next of Kin’s Name:** | **Relationship:** |
| **Contact Number:** |

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| **If the patient registering is under 18 years old, please give us name and contact number of parents/guardians.** | |
| Parent 1: | Contact Number: |
| Parent 2: | Contact Number: |
| **Local School/Nursery attended** | |

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| **Do you look after someone/Are you a carer?** |  | **Does someone look after you/Do you have a carer?** |
| What relationship is the person you care for? | Carers name: |
| Carers contact number: |

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| **Do you suffer from any of the following?** (Please circle/Give details if necessary) | | | | |
| Asthma | Epilepsy | Diabetes | | Stroke |
| TB | Heart attack | Heart Problem | | Cancer |
| Depression | Mental Health Illness | COPD | | High Blood Pressure |
| Thyroid | Dementia | Atrial Fibrillation | |  |
| Any other important illnesses? | | | | |
| **Are you allergic to any medicines or dressings?** | | | Please give details: | |

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| **Please attach a repeat slip for any repeat medications you are currently taking** |

**If you’d like to nominate a pharmacy to send your prescriptions electronically to please state here:**

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| **Do you smoke?** | **Are you an ex-smoker?** |
| If Yes how many a day? | Would you be interested in smoking cessation advice? |
| **How many units of alcohol do you drink in a typical week?** [ ]  (one unit is a glass of wine, one measure of spirit or half a pint of beer) | |
| **What is your height in metres?** | **What is your weight in kg?** |

**Are you homeless or an asylum seeker?** If so please let us know as we can offer you a free health assessment and support and can signpost you to additional services who will be able to help you!

Please Circle.

**I am currently homeless**  **I am an asylum seeker**

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| **Summary Care Record -** The intention of the SCR is to help clinicians in Hospital A&E Departments and GP ‘Out of Hours’ health services to give you safe, timely and effective treatment  See attached information on Summary Care Records for further information |
| [ ] I Express **consent** for medication, allergies and adverse reactions only |
| [ ] I Express **dissent** – I do not want a summary care record & fully understand the risks involved with this decision (If you wish to OPT out please complete the document attached) |
| |  |  | | --- | --- | | **EDSM – ENHANCED DATA SHARING MODEL -** Allowing your GP to share your record in the “SystmOne” database helps to deliver better and safer care for you | | | **Sharing Out –** Do you consent to the sharing of data recorded by your GP practice with other NHS organisations that may care for you? | **YES NO**  (please circle) | | **Sharing In –** Do you consent to your GP Practice viewing data that is recorded at other NHS organisations and care services that may care for you? | **YES NO**  (please circle) |  |  | | --- | | **To opt out of the Virtual Patient Participation Group (PPG) put a tick this box** [ ] | |  | |
| **Your allocated named General Practitioner will be Dr Lucy Laurance.** However, we are a group practice and as such you are still able to see any GP for your problem depending on availability. |