(Adult) New Patient Questionnaire

Please **FILL IN** this confidential form in **BLOCK CAPITALS** and **tick the boxes** as appropriate. (one for each member of the family to be registered with the Practice)

So that we can process your registration, please also **bring with you:**
Photographic ID *(passport, UK photocard driving licence or nationally recognised photo ID)* *and at least one* **proof of address document** *(utility bills or recent bank statements. If you are unsure, please speak to a receptionist)*

1. Patient Details

NHS No.		**Town & Country of Birth**	
First Name		**Surname**	
Known as	*(if different from first name)*	**Date of Birth:**	

Gender: Male ☐ Female ☐ Indeterminate ☐ Unspecified / Unknown ☐

Marital Status: Single ☐ Married ☐ Divorced ☐ Co-habiting ☐ Separated ☐ Widowed ☐

Ethnicity

White	**Black, African, Caribbean or Black British**	**Asian / Asian British**	**Mixed or Multiple ethnic groups**
English, Welsh, Scottish, Northern Irish or British ☐	African ☐	Indian ☐	White and Black Caribbean ☐
Irish ☐	Caribbean ☐	Pakistani ☐	White and Black African ☐
Gypsy or Irish Traveller ☐	Any other Black, African or Caribbean background ☐	Bangladeshi ☐	White and Asian ☐
Any other White background ☐		Chinese ☐	Any other Mixed or Multiple ethnic background ☐
		Any other Asian background ☐	

Other Ethnic group: Arab ☐ Any other ethnic group ☐

Other:

Employment Status

Employed ☐ **Occupation:**

Self-employed ☐ Employed / Paid Carer ☐ Unemployed ☐ Retired ☐

Are you a Military Veteran? Yes ☐ No ☐ **Family Member in Military?** Yes ☐ No ☐

Language | **Interpreter Needed** Yes ☐ No ☐

Religion

C of E ☐	Buddhist ☐	Sikh ☐	No religion ☐
Catholic ☐	Hindu ☐	Jewish ☐	Other:
Other Christian ☐	Muslim ☐	Jehovah's Witness ☐	

Housing

Own Home ☐	Rented Home ☐	Supported Home ☐	Temporary Housing ☐
Homeless ☐	No Fixed Abode ☐	In Care ☐	Refugee ☐
Live Alone ☐	Live with Family ☐	Live with Children ☐	Other:

2. Contact Details & Address				Preferred
Home Phone				☐
Mobile Phone				☐
Work Phone				☐
E-mail				
Consent	If you give us a mobile and/or email we will assume you are happy for us to contact you using them. If you are **NOT** happy to be contacted this way please tick the box : ☐			
Current Address				**Postcode**
Address Type	Home ☐	Temporary ☐	Correspondence Only ☐	Other:

3. Family, Relationship & Emergency Contact Details	
Next of Kin Name	
Next of Kin Contact Number	
Next of Kin relationship to you	
Names & Ages of Children	
Other individuals in your household	
Emergency Contact/s *(name, number & relationship)*	

4.Carer Details			
Do ***you*** have a carer who *you* are **dependent on** for some or all of the time?			Yes ☐ (has a carer) No ☐
Name of Person		**Patient at this practice?**	Yes ☐ No ☐
Relationship to you	Child (young carer) ☐ Relative ☐ Other:		
Type of Carer	Informal ☐ Paid ☐ Parent ☐ Other:		
Carer **Address** *(if different to yours)*			
Carer **Home Phone Number**		Carer **Mobile Phone Number**	
Carer **Email Address**		**Does the carer hold a care plan for you?**	Yes ☐ No ☐
I am happy for you to share my health care record / information with my carer :			Yes ☐ No ☐
Would you like information on support services for carers?			Yes ☐ No ☐

Are ***you*** a carer who **looks after someone** else dependent on you for some or all of the time?	Yes ☐ (is a carer) No ☐
Relationship to you	Friend ☐ Neighbour ☐ Relative ☐ Other:
Their Condition	Physical Disability ☐ Mental Health Problem ☐ Terminal Illness ☐ Learning Disability ☐ Chronic Disease ☐ Sensory Impairment ☐ Dementia ☐ Alcohol Misuse ☐ Other: Substance Misuse ☐ Elderly ☐
Would you like information on support services for carers?	Yes ☐ No ☐

5. Your Medical Information

Height		**Weight**	

Alcohol Consumption

2	3	1.5	2	2	2	1
Pint of regular beer, lager or cider	Pint of premium beer, lager or cider	Alcopop or can/bottle of regular lager	Can of premium lager or strong beer	Glass of wine (175ml)	Large glass of wine (250ml)	Single measure of spirits

How often do you have a drink containing alcohol?	Never ☐	Monthly or 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? (see above)	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 ☐
How often during the last year have you found that you were not able to stop drinking once you had started?	N/A ☐	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never or N/A ☐	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 or N/A ☐	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 or N/A ☐	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 or N/A ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily or almost daily ☐
Have you or somebody else been injured as a result of your drinking?	N/A ☐	No ☐	Yes, but not in last year ☐	Yes, during the last year ☐	
Has a relative or a friend, Doctor or other health worker been concerned about your drinking or suggested you cut down?	N/A ☐	No ☐	Yes, but not in last year ☐	Yes, during the last year ☐	
A member of our clinical team may call you to discuss your drinking. If you would rather not be contacted, please indicate by ticking this box.					☐

Smoking Status	Never Smoked ☐	Ex Smoker ☐	Light Smoker ☐ <10 day	Moderate Smoker ☐ 11-19 a day	Heavy Smoker ☐ >20 a day	Vaping ☐
Diet	Good ☐		Average ☐		Poor ☐	
Exercise	Heavy ☐	Moderate ☐	Light ☐	No Exercise ☐		

Have you ever or are currently suffering from any of the following conditions?

Arthritis ☐ Asthma ☐ Autoimmune Disease ☐ COPD ☐ CVA ☐	Dementia ☐ Depression ☐ Diabetes ☐ Epilepsy ☐ Heart Failure ☐	Hypertension ☐ Heart Disorder ☐ Kidney Disease ☐ Liver Disease ☐ Peptic Ulcer Disease ☐	Thyroid Disorder ☐ Stroke ☐ Cancer ☐ - Please specify below:

Any other relevant past medical history	Previous operations / surgical procedures
Previous hospital admissions	Currently being seen at a hospital clinic
Are you allergic to any medications?	Any other allergies? e.g. animals, dust

Nominated Pharmacy for Electronic Prescriptions (EPS)
If your prescriptions go directly to a pharmacist and you want us to add this to your record, then please let us know the name and address below:

Name of pharmacy:
Address of pharmacy:

Your Family History			
Please tell us about any important family history of close relatives with medical problems and confirm which relative e.g. Mother, Father , Grandparent or Sibling (brother or sister)			
Condition (tick all that apply)	**Which relative?**	**Condition** (tick all that apply)	**Which relative?**
Arthritis ☐		Heart Failure ☐	
Asthma ☐		Hypertension ☐	
Autoimmune Disease☐		Heart Disease ☐	
COPD☐		Kidney Disease ☐	
Cardiovascular Problem ☐		Liver Disease ☐	
Dementia ☐		Peptic Ulcer Disease ☐	
Depression ☐		Thyroid Disorder ☐	
Diabetes ☐		Stroke ☐	
Epilepsy ☐		Cancer ☐	
Other relevant family history not listed above:			

5a. Women Only	
Do you use any contraception?	Yes ☐ No ☐ If needed, please book appointment.
Are you currently pregnant?	Yes ☐ No ☐ Expected due date: dd / mm /yyyy
Date of last smear test	dd / mm /yyyy

6. Accessible Information Needs				
Condition / Issue	Registered Blind ☐	Registered Deaf ☐	Other:	
When we speak to you	British Sign Language ☐	Lip reader ☐	Hearing aid ☐	Other:
When we write to you	Braille ☐	Large print ☐	Easy read ☐	Other:
Preferred Contact Method	Telephone ☐	Text message ☐	Post ☐	Other: Email ☐
Other Communication Needs				

7. Association(s) with Medical Practice	
To the best of your knowledge, are any of your relatives or friends currently employed by the Medical Practice?	
Yes ☐	No ☐
Staff note: If 'Yes' to question above, advise patient of staff records access policy	

8. Online Access

Online access to your GP record allows you to;

- Renew or order repeat prescriptions, book or cancel appointments online and view your gp record

You can sign up for online services from a tablet or smart phone rather than having to visit or call the practice by using the **NHS app** – visit **www.nhs.uk/using-the-nhs/nhs-services/the-nhs-app or scan the QR code**

NOTE: To access your record you will still need to show ID to the practice

SCAN ME

Would you like to register for online services?	Yes ☐ (Complete section 7a) No ☐ (Go to section 8)

To register in practice you should provide a valid photo ID and proof of address

7a Complete this section only if you wish to have online access

Please indicate what online services you would like access to (please tick all that apply):	
Booking appointments	☐
Requesting repeat prescriptions	☐
Accessing my medical record	☐
I wish to access my medical record online and understand and agree with each statement	
I have read and understood the information leaflet provided by the practice	☐
I will be responsible for the security of the information that I see or download	☐
If I choose to share my information with anyone else, this is at my own risk	☐
If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible	☐
If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	☐
If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible.	☐

9. Record Sharing For Direct Care

What is direct care?

Direct care means that a health worker caring for you wishes to access information held in your GP record that will help them to treat you better. **This data is NEVER used for research purposes or marketing.**

Local Record Sharing for Direct Care

Your GP record can be made available to other health care services such as out of hours, emergency services, other GP practices, community services and hospital consultants.

You will be asked every time by anyone accessing your GP record from outside the practice.

I am happy to share my GP record to local care services	☐
I do NOT wish to share my GP record to local care services * *Please arrange to speak to a member of staff to ensure you do not compromise the care you might be given	☐

SCR Sharing for Direct Care

SCR information line: 0300 123 3020 www.nhscarerecords.nhs.uk

The Summary Care Record (SCR) is a national scheme used to support your direct care. The information will be very limited, and includes medication, allergies and adverse drug reactions.

You will be asked every time by anyone accessing your SCR from outside the practice (unless you cannot give permission).

I am happy to have a summary care record created	☐
I do **NOT** wish to have a summary care record created * *Please arrange to speak to a member of staff to ensure you do not compromise the care you might be given	☐

10. Signatures

I confirm that the information I have provided above is true to the best of my knowledge.			
Signature			
	Signed by patient ☐	Signed on behalf of patient ☐	
Name		**Date**	

11. Checklist

Thank you for completing this form. Please check you have completed all sections where possible.

Please ensure that you bring the following with you to the surgery to complete your registration:

1.	**Completed & Signed New Patient Registration Questionnaire** (this form!)	☐
2.	**Completed & Signed GMS1 Form**	☐
3.	**Photo Proof of ID** - e.g. Passport, Photo Driving License or Photo ID card	☐
4.	**Proof of Address** – ***Must be in your name and dated within the past 3 months*** – *Provided in one of the following:* Bank statement, Utility Bill (Gas, Electricity, Water), Council Tax, Tenancy Agreement or Landline Phone Bill (Mobile phone bills are not accepted)	☐
5.	If possible, your **Immunisation Records** – usually the Personal Child Health Record ("Red Book")	☐
6.	If possible, your **NHS Card** – usually shows your previous GP and your NHS Number	☐
7.	If relevant, your **Repeat Medication Request Slip** from your previous GP	☐
8.	If relevant, your **European Health Insurance Card**	☐

Thank you for completing this form – please return it to reception

For General Practice Use Only				
Photo ID	Passport ☐	Driving licence ☐	Identity card ☐	Other ☐
Proof of Address	Utility Bill ☐	Council Tax ☐	Bank Statement ☐	Other ☐

☐ Photo I.D confirmed with patient present