**NEW PATIENT QUESTIONNAIRE**

To register with the practice, please complete this questionnaire as fully as possible. The information will help the doctor to make an initial assessment of your health which will help in your future treatment. Patients will be asked to attend the practice for an initial consultation and some basic checks. You also have attached various other forms that you will need to complete regarding different aspects of you care.

Please Circle or Fill in as necessary.

\* The registration form GMS1 and patient questionnaire

* A form to register for online services (Optional)
* A consent form regarding sharing of information
* A form to join the patient participation group PPG (Optional)

**Surname: …………………………………………………….Forename(s): ……………………………………**

**Date of Birth: …………………………………………….. Marital status: ….……………………………..**

**Address: …………………………………………………………………………………………………………………**

**……………………………………………………………….……Postcode: ....…………..……………………….**

**Home Telephone: ……………………………………… Mobile: ………………………………………….**

**email address: ………………………………………………………………………………………………………**

**Occupation: ………………………………………………………………………………………………………….**

**Weight (approx.): ……………………………………….Height: …………………………………………..**

**Next Of Kin Details:**

**Name……………………………………………………….. Relationship……………………………………..**

**Contact Number………………………………………..email………………………………………………..**

**This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act. Please indicate your ethnic origin. 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 the early identification of some of these conditions.**

**Choose ONE section from A to E, and then tick ONE box to indicate your background.**

**A White**

|  |  |
| --- | --- |
|  | **British** |
|  | **Irish** |
|  | **Any other white background, please state:** |

**B Mixed**

|  |  |
| --- | --- |
|  | **White and Black Caribbean** |
|  | **White and Black African** |
|  | **White and Asian** |
|  | **Any other mixed background, please state:** |

**C Asian or Asian British**

|  |  |
| --- | --- |
|  | **Indian** |
|  | **Pakistani** |
|  | **Bangladeshi** |
|  | **Any other Asian background, please state:** |

**D Black or Black British**

|  |  |
| --- | --- |
|  | **Caribbean** |
|  | **African** |
|  | **Any other black background, please state:** |

**E Chinese or other ethnic group**

|  |
| --- |
|  |

**What is your first Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have a second Language: \_\_\_\_\_\_\_\_\_ If yes which Language?\_\_\_\_\_\_\_\_\_**

***Smoking:***

Do you smoke?  ***Yes* / *No***

If *Yes*, how many Cigarettes per day Ounces of tobacco per day How old were you when you started smoking?\_\_\_\_\_

***Ex-Smokers:***

How old were you when you stopped smoking?

How much did you smoke per day?

***Passive Smoking:***Are you exposed to passive smoke at work *Yes /*  *No*

Where at home? ***Yes* / *No***

***Drug User:***

*Please answer the following questions:*

*If you have a history of drug use it will help the doctor in assessing your treatment if you circle the following quotes.*

**What time of day do you usually start using drugs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is there a pattern to the use?\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What effects do drugs have on you?** (**Please Circle**)

Feel happier Feel more important Feel more alert Reduces physical discomfort

Increased irritability less shy Think more clearly more creative Have more fun Reduce stress/tension Help to sleep Relax socially Express myself more easily Avoid negative emotions (depression, anger,)

Forget something that happened Concentrate better

**Have you ever experienced any of the following symptoms when you use drugs?**

(**Please Circle**)

Seizures Blackouts - Hallucinations - Paranoia - Personality changes

Decreased need for sleep Increased aggression - Increased sexual arousal

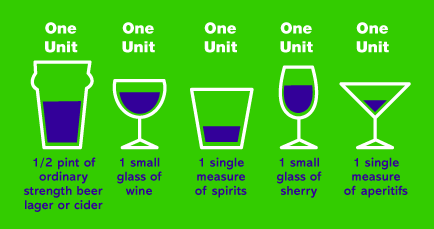
Severe weight loss - Ulcers or other stomach problems - Headaches

Excessive bleeding Heart palpitations - Suicidal thought Panic attacks Memory problems - Depression Loss of sex drive

***Alcohol:***

***Information from this alcohol use questionnaire can help determine if you should see a health care professional regarding your alcohol use. It should only be used as a***

***Guideline and it does not replace a formal***

***Medical evaluation: If you drink alcohol and answer "Yes" to more than one of these questions, talk to your doctor.***

***Do you drink?***

***If so, have you ever wondered if you drink too much? Recommended Units***

***Do you ever drink more than you intend to?***

***Has there been any change in your tolerance of alcohol?***

***Has drinking ever caused any problems in your life?***

***Has a family member ever been concerned about your drinking?***

***Have you ever decided to quit drinking for a while or cut down your drinking?***

***Have you felt guilty about your drinking?***

For the following questions please circle the answer that best applies:

**One drink = 1/2 pint of beer/one glass of wine/one single measure of spirits**

Men: How often do you have EIGHT or more drinks on one occasion?

Women: How often do you have SIX or more drinks on one occasion?

*Never* ***Less than monthly******Monthly***  ***Weekly******Daily/Almost Daily***

How often during the last year have you failed to do what was normally expected of you because of drinking?

*Never* ***Less than monthly******Monthly*** ***Weekly******Daily/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/Almost Daily***

In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down? ***Yes / No***

***Sexuality:***

In the interest of your health care the answers to the following questions could be of benefit. The questions are however optional. These are the basic types of sexual orientations: Which one would be applicable to you?

Heterosexual Bisexual Lesbian Gay

**Have you or do you think you would benefit from HIV or Hebetates screening**? ***Yes/ No***

***Diet:***

Do you add salt to your food after cooking?  ***Yes* / *No***

Do you have a varied diet including milk, meat, vegetables and fruit? ***Yes* / *No***

Has your cholesterol been checked in the last two years? ***Yes* / *No***

***Exercise:***

Do you take regular exercise? ***Yes* / *No***

If yes, what sort of exercise?

How many minutes do you typically spend exercising per session?

How many times do you exercise per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there any of the following in your family *(father, mother, brother, sister) that was diagnosed* before the age of 65?

**With:**

**Heart Disease (e.g. heart attacks, angina) *Yes* / *No which Family Member?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**Stroke? *Yes* / *No* which family member?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cancer? *Yes* / *No* which family member?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If yes to the Cancer question please indicate which type?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Medication:***

**Please give details of any medication which you take (prescribed or otherwise):**

**Name of drug: ……………………………………Dosage: …………………………………………….**

**Name of drug: ……………………………………Dosage: ……………………………………………..**

**Name of drug: ………………………………….. Dosage: ……………………………………………..**

***Allergies:***

**Are you allergic to any substances or foods? *Yes* / *No***

**If *yes*, please give details:**

**…………………………………………………………………………………………………………………………………………**

**………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………**

***Past Medical History:***

**Please give details of any hospital treatment as an in-patient:**

**……………………………………………………………………………………………………………………………………**

**……………………………………………………………………………………………………………………………………**

**Please give details of any treatment for any chronic medical conditions:**

**……………………………………………………………………………………………………………………………………**

**……………………………………………………………………………………………………………………………………**

**Please give dates of any X-ray/MRI or CT scans/mammogram/ultrasound.:**

**……………………………………………………………………………………………………………………………………**

**…………………………………………………………………………………………………………………………………..**

***Immunisations:***

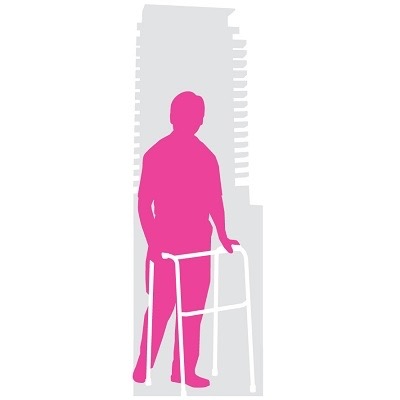
**Dates of triple/polio/HIB: …………………………………………..Dates of MMR……………………………………………..Date of last Tetanus:………………………………… …………**

**Female Patients:**

**Date of most recent cervical smear: ………………………….Result of most recent smear…………………………………………**

**Please give details of any complications in pregnancy: ……………………………………………………………………………………………………………………………………**

**……………………………………………………………………………………………………………………………………**

****

***Carers:***

Do you need / have anyone who looks after you or your daily needs as a Carer? ***Yes* / *No*** If *yes*, would you like them to deal with your health affairs here? ***Yes* / *No***

**The receptionist can help with these arrangements**

Do you care for anyone else?  ***Yes/ No***

**If *yes*, please ask the receptionist about Carers support**

***Child Additionnel Questionnaire***

**C:\Program Files (x86)\Microsoft Office\MEDIA\CAGCAT10\j0216724.wmf**

***Please indicate if this form is form a child Yes/ NO***

**Your child will have regular health and development reviews during their early years. These are to make sure they stay healthy and are developing normally.**

**Height……………………. Weight…………………………………………………….**

**Please describe any special diet you are following………………………………………………………………….**

**………………………………………………………………………………………………………………………………………………**

**………………………………………………………………………………………………………………………**

**Please attach a copy of the child’s immunisation history. Please bring the child’s red health visitors book when attending appointments.**

***General:***

Are there any other issues which cause you concern or would you like advice on any other health problems? Please give details below:

**………………………………………………………………………………………………………………………**

**………………………………………………………………………………………………………………………**

**………………………………………………………………………………………………………………………**

***REGISTERING TO USE OUR ON-LINE – SERVICES***

We are very pleased to inform patients that you can now access a range of online services via

Our website **Website: www.themedicalcentreislington.co.uk**

**The current services available are**:

\*Online appointment booking with doctors

\*Online repeat medication requests

\*Summary Care Record

\*Patient questionnaires to help us keep your record up to date

This follows feedback from recent patient surveys and the introduction of a new computer system.

We hope to be able to develop the range of online services available to our patients in

due course. Please note that these online services cannot be used to contact the practice for

other medical matters.

We also offer text message appointment reminders. If you prefer not to receive text messages

please indicate below.

In order to be able to access on-line services you simply need to complete the form below and

return it to the reception desk in person WITH your passport or photo-id. We will take a copy

for verification purposes and return it to you with your log on details.

**I would like to have access**

**to online services at The Medical Centre**

**Please let us know if you**

**Would like to collect**

**Your medication from your Chosen pharmacy**

**Passport copy attached:**

**Name:**

**Date of Birth**

Sharing your medical information

Health professionals are trained to keep your records secure and to manage them responsibly and in confidence.

Your GP can now see your medical record held in other health organisations that provide your care e.g. your hospital or health centre. Health professionals e.g. your hospital doctor, district nurse, or physiotherapist treating you can also see your full GP record if you give your permission when they see you.

Sharing your records benefits you because:

#### You won’t need to repeat your medical history.

#### You avoid unnecessary appointments and tests.

#### Your health professional has the right information at the right time.

**Please enter your name and dob and select one option for 1) and 2)** Name: ………………………………………………. Date of Birth: ……………..……..

|  |  |
| --- | --- |
|  | **1) Your practice sharing your record with other healthcare organisations** **Yes**, I am happy for my GP practice to share my full medical record with other organisations providing my care.**No**, do not share my medical records with other organisations. N.B. Selecting no might delay your treatment or mean repeated tests. Professionals and emergency departments will not have up to date information about you. |
|  | **2) GP practice seeing your record from other healthcare organisations** **Yes**, I am happy for the GP practice to see records held about me by other organisations providing my care.**No**, I do not want the GP practice to see records held about me by other organisations. N.B. Selecting No means that your GP might not have up to date information from other organisations to continue caring for you safely. Mistakes could be made because your information from other organisations is not joined up. |

***PATIENT PARTICIPATION GROUP APPLICATION FORM***

Making Services Better: Your Views Matter

We committed to improving the services we provide to our patients .

***To do this, it is vital that we hear from people like you about your experiences, views, and ideas for making services better. The Patient Participation Group (PPG) will meet at the practice once a month.***

***If you are interested in getting involved, please complete and return this form to the assistant Practice Manager.***

***By expressing your interest, you will be helping us to plan ways of involving patients that suit you. It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice.***

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Postcode:** |  |
| **Email Address:** |  | | |

**What sort of things might you be interested in taking part in? *Please tick all Blank boxes that apply to you.***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Are You?** | **Male** |  | **Female** |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Age Group** | **Under 16** |  | **17 – 24** |  | **25 – 34** |  |
| **35 – 44** |  | **45 – 54** |  | **55 – 64** |  |
| **65 – 74** |  | **75 – 84** |  | **Over 84** |  |

To help us ensure our contact list is representative of our local community, please indicate which of the following ethnic background you would most closely identify with?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **White:** | | | | | |
| British Group |  | Irish |  |  | |
| **Mixed:** | | | | | |
| White & Black Caribbean |  | White & Black African |  | White & Asian |  |
| **Asian or Asian British:** | | | | | |
| Indian |  | Pakistani |  | Bangladeshi |  |
| **Black or Black British:** | | | | | |
| Caribbean |  | African |  |  | |
| **Chinese or other ethnic Group:** | | | | | |
| Chinese |  | Any Other |  |  | |

How would you describe how often you come to the practice?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Regularly |  | Occasionally |  | Very rarely |  |

*Thank you. We will contact about joining the PPG*

*Please note that no medical information or questions will be responded to.*

**The information you supply us will be used lawfully, in accordance with the Data Protection Act 1998The Data Protection Act 1998 gives you the**

**right to know what information is held about you, and sets out rules to make sure that this information is handled properl**

***Registration Check List:***

**Please Circle where appropriate when you have checked all the forms in the pack. Always ask if patient has a NHS number or NHS card or has previously been registered in the UK. For babies please ask for copies of immunisation card/Red book and if possible a copy of the birth certificate.**

**Proof of Name (ID). *You must provide one of the following:***

* **Current passport(with valid Visa non-EU passports)**
* **Residence permits issued by the Home office to EU Nationals on sight of own country**
* **Current UK photo card driving license( full UK only)**
* **Birth Certificate**
* **Adoption Certificates**
* **Marriage/Civil Partnership Certificates**
* **Police photographic ID card**

**Proof of Address.  *You must provide one of the following:***

* **Recent (within the past three months) original utility bill e.g. ‘Electricity/Gas/Water/Telephone.**
* **Local authority council tax bill**
* **Bank or building society statement(Within the past three months**
* **parents documentation from “Proof of address “list (for 16-17 year olds only) This must be provided with a birth certificate or adoption certificate bearing the parents name which can be used as proof of name**
* **Current book or card or original notification letter from the Department for Work & Pensions**
* **Court order within the past 12 months**

***For Official Use Only***

**Administrator dealing with forms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Seen ID Passport:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Seen Proof Of Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Seen Immunisation Records\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Fully Completed Registration/Forms\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_D.O.B\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Thank you for completing this questionnaire. Your doctor will assess the information   
provided and we will invite you for an initial examination, discussion about your health, and general check within the next few weeks.**