NEW PATIENT QUESTIONNAIRE - IT IS IMPORTANT TO COMPLETE ALL SECTIONS

Full name ……………………………………………………………………….. Date of Birth ……………………

Address……

Postcode……………… NHS Number (if known) ………………………… Marital Status S/M/W/Other

Contact Numbers: Home……………………… Mobile…....................................... Work ……………………………..

Email address:(please print) Religion ………..……………………

Which country were you born in? …………………………… If not English, main spoken language……………………………..

Do you give us permission to contact you via your mobile if we need to? Yes / No
Do you give us permission to contact you via email if we need to? Yes / No

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Do you smoke? Y/N If yes, how many a day………….…….. What age did you start smoking ………………

Ex- smokers: Year stopped………….. How many did you smoke a day? ……………

How often do you have a drink that contains alcohol: *Never* ☐ *Monthly or less* ☐ *2-4 times per month* ☐ *2-3 times per week* ☐ *4+ times per week* ☐

How many standard alcoholic drinks do you have on a typical day when you are drinking?
1- 2 ☐ *3-4* ☐ *5-6* ☐ *7-8* ☐ *10+* ☐

How often do you have 6 or more alcoholic drinks on one occasion?
Never ☐ *Less than monthly* ☐ *Monthly* ☐ *Weekly* ☐ *Daily or almost daily* ☐

CURRENT MEDICATION ***(ie Paracetamol 500mg, one per day, back pain) OR ATTACH MEDICATION SHEET***

1. Name & strength: ………………………………………………………… Dosage per day …………………………
   Why do you take this medication ……………………………………Year diagnosed ………………………
2. Name & strength: ………………………………………………………… Dosage per day …………………………..
   Why do you take this medication …………………………………… Year diagnosed ………………………
3. Name & strength: ………………………………………………………… Dosage per day …………………………..
   Why do you take this medication …………………………………… Year diagnosed ………………………
4. Name & strength: ………………………………………………………… Dosage per day …………………………..
   Why do you take this medication …………………………………… Year diagnosed

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HAVE YOU EVER HAD SIDE EFFECTS FROM ANY MEDICATION?

Name & strength: ……………………………………… Side effect ………………………………………………….……….

Name & strength: ……………………………………… Side effect ……………………………………………..…………

OTHER IMPORTANT ILLNESSES/OPERATIONS/ACCIDENTS (continue overleaf if necessary)

Year ……………….…….. Description ……………………………………………………………….

Year …………………….... Description ……………………………………………………………….

Year ………………….….. Description ……………………………………………………………….

FAMILY HISTORY	**If alive, serious illnesses**	**If dead, cause of death and age when died**
Father	……………………………………………………	……………………………………………………….…
Mother	……………………………………………..	…………………………………………………………
Brothers	………………………………………………..	………………………………………………….……
Sisters	……………………………………………………	…………………………………………………………

PLEASE TURN OVER >

EMERGENCY CONTACT PERSON

NAME ………………………………………………………………………. RELATIONSHIP ……………………………………………………………

ADDRESS ……………………………………………………………………………………………………POST CODE ………………………………

CONTACT TELEPHONE NO. ……………………………

CARERS

Do you look after someone who is frail, elderly, disabled or mentally ill YES ☐ NO ☐
or who has a general health problem. This could be a family member, friend or neighbour.

Do you have a carer who looks after you? YES ☐ NO ☐
If so, please give the details of that person below.

INFORMATION AND COMMUNICATION NEEDS

Do you have any communication / information needs relating to a disability or sensory loss, ie blindness needing Braille Or information supplied in large print, deafness needing sign language, unable to read so would need verbal information, information in a language other than English.

YES ☐ NO ☐ (XaR7G)

If yes, what are these needs? ………………………………………………………………………………..………………

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Have you ever served in any of the armed services **(Xa8Da)** YES ☐ NO ☐

NHS England have said that from 2015, every patient has to have a 'named' GP who is responsible for their care recorded on their records.

This is a paper exercise only and it makes no difference whatsoever to the care you receive from the surgery and you are still able to see whichever doctor you wish or who is on duty.

Please 'tick' which doctor you would like as your named GP: **Dr Saul Miller** ☐

Dr Clare Bromly ☐

<u>SHARING YOUR RECORDS WITH OTHER USERS WHO YOU MIGHT SEE</u>

If you are referred by the doctors to other healthcare workers who use the same clinical system as ours, SystmOne, they are able to access your records but only if you give permission. These workers would be, district nurses, health visitor, physiotherapist, podiatrist (chiropodist). As with everyone who has access to your records in the surgery, they are only allowed to access those parts of your record which are relevant to what you are being treated for under Access to Records and the Data Protection Act.

Please tick as appropriate:

I agree to sharing of my clinical record with other users who may need access for treatment purposes ☐

I DO NOT agree to sharing of my clinical record with other users who may need access for treatment purposes ☐