New Patient Questionnaire Form

Please complete this confidential questionnaire (one for each family member to be registered)

Please complete in BLOCK CAPITALS and tick the boxes as appropriate.

We require the following identification:

1 Personal ID: Birth Certificate, Marriage Certificate, Driving Licence, Passport

1 Address ID: Local Authority Rent Card, Utility Bill, Bank/Building Society /Credit Card Statement

If you are newly arrived in this country, please bring your passport

Full Name:	**Telephone Number:**
Mr / Mrs / Miss / Ms / Other……..	**Work Number**
Address and Postcode **Any care/residential home add code XaMFG**	**Mobile Number:** Consent to receive text messages **Y/N** **E-mail Address:** **Next of Kin & relationship to you:** **Next of Kin Contact Number:**

Date of Birth:		**Previous / Mother's surname if different:**		**Town & Country of Birth**
Marital Status:		**Gender:**	Male:	Female:
Occupation:				**Preferred method of communication** □ **Letter** □ **Email** □ **SMS texting** ADD readcode XaQmO
Names & Ages of Children				

Your height:	Feet / inches	m/cm	**Your weight:**	Stones / lbs.	kg

Your Religion:	C of E	Catholic	Other Christian (state)	Buddhist	Hindu	Muslim
	Sikh	Jewish	Jehovah's Witness	No religion	Other religion (state)	

Your Ethnic Origin: (select one)	White (UK)	White (Irish)	White (Other)
Caribbean	African	Asian	Other Mixed Background
Indian / British Indian	Pakistani / British Pakistani	Bangladeshi / British Bangladeshi	Other Asian Background
Other Black Background	Chinese	Other please state	Ethnic Category not stated

Your main or 1st language Spoken / Understood: (select one)	English	Hindi	Guajarati	Urdu	Bengali	Punjabi

Polish	Ukrainian	French	German	Spanish	Other: (Please Specify)

Smoking, Alcohol Consumption and Exercise:

Are you currently a smoker?	Yes	No	**Have you ever been a smoker?**	Yes	No
If so, how many cigarettes / cigars / tobacco do you smoke in a week?			*If you are a smoker and want to stop, please call 0800 246 5343 OR text free: QUIT to 66777 for smoking cessation services*	Yes	No

How often do you have a drink that contains alcohol in a week?	*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	7-9	10 +
How often do you have 6 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

If you would like information or help reducing the amount of alcohol you or someone you know drink, talk to your GP. Alternatively please contact www.cri.org.uk or call on telephone 0115 896 0798.

Your Medical Background:

What recent illnesses have you had & When?	
What recent operations have you had and When?	

Do you have any medical problems at present?	Diabetes	Heart Attack	Heart attack under age of 60	Bowel Cancer	
	Breast Cancer	Dementia	High Blood Pressure	Asthma	Stroke
	Thyroid Disorder		Any other important Illness?		

Please list any medication you are currently taking: incl. dose/frequency	Or attach your repeat prescription list If you are taking Warfarin, please advise reception when your next test is due.

NHS Electronic Prescription Service	YES/NO	**Sending your prescriptions directly to the pharmacy, will save you from coming to collect them from the practice.**
	If yes admin add code YES NO **XaZMS XaZbd**	**Please write the name of your preferred pharmacy below.**

Significant Family History	Diabetes	Heart Attack	Heart attack under age of 60	Bowel Cancer	
	Breast Cancer	Dementia	High Blood Pressure	Asthma	Stroke

please tick Travel Advice-if applicable	Thyroid Disorder We need **8 weeks notice** of any foreign travel. Forms available online or reception	Any other important Family Illness? Date of travel:

Please state any Sensory Impairment you have (i.e. Speech, Hearing, Sight): and any communication or information needs relating to this		
Please state any Physical disabilities you have and any communication or information needs relating to this		
Please state any Mental disabilities you have and any communication or information needs relating to this		
Please state any requirements you have to be able to access the Practice premises		
Please state any Religious or Cultural needs:		
Do you require the help of a Translator / Interpreter?		
Please state any allergies and sensitivities you have:		
Access on online services – photo ID required Prescription order/appointment booking	**Yes**	**No** **Admin Code XaeEr**
If you are a Carer, please state the name / address / phone number of the person you care for: Admin add code Ua0VL	Person Cared For Contact Details:	
If you have a Carer who is a family member or friend, please state their name, address & phone number and sign here if you wish us to disclose information about your health to them. Admin add code XaNwR	Carer Contact Details: Signed: Date:	
Do you have a "Living Will" Or RESPECT form? (a statement explaining what medical treatment you would not want in the future)	Yes / No	If "Yes", can you please bring in a written copy of it so we can add into your notes
Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney or who has Third Party sharing consent)? Admin add code XaNwR	Yes / No	If "Yes", please state their name / address / phone number:

Women only:

When was your last smear done?	Date	**Was this at your GP's Surgery?**	Yes	No

What was the result of the smear?			
Date of last mammogram (if applicable):	Date	**Method of contraception (if used):**	
Do you wish to see a doctor in this practice for contraceptive services (including the pill, coil or cap)?		Yes	No

Summary Care Records.

The NHS Summary Care record is an electronic record of important information about your health. It contains information about the medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had in the past. It will be available to Emergency health care staff and GP out of hours services providing your NHS Care to be better equipped to treat you. Ask reception if you require further information.

Are you happy to have a Summary Care Record?	Yes	No Admin add XaXj6	

Shared Care

The NHS Care record is an electronic record of important information about your health.
It will be available to health care staff providing your NHS Care. An information leaflet has been provided.
We will only share out your information with other health professionals with your consent. Wherever possible we aim to have your explicit consent i.e. verbal or written, sometimes however in relation to referring you to hospital for instance the consent may be implied i.e. because you have agreed to a referral to hospital we have to pass your information onto the hospital in order that they may treat your problem. Any health professional apart from your GP practice will still have to ask to look at your record even if you have consented to share.

Are you happy to share your record with other local healthcare professionals involved in your care?	**Yes** Admin add XaMdS	**No** Admin add XaQVo

Patient Participation Group

The Practice is committed to improving the services we provide to our patients.
To do this, it is vital that we hear from people about their experiences, views, and ideas for making services better.
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.
If you are interested in getting involved, please tick the box below and we will arrange for the Practice Patient Participation Group to contact you.

Yes, I am interested in becoming involved in the Practice Patient Participation Group (Please tick the "Yes" Box)	Yes

Patient Signature:		**Signature on behalf of Patient:**	
Date		**Date**	

You can book a **new patient check** with the nurse.
If you have repeat **medication** including the **contraceptive pill** you **WILL NEED** to have a **new patient check** with the Practice Pharmacist or nurse.
The examination will include having your height, weight and blood pressure taken, and a specimen of urine for testing (it would be helpful if you would bring a specimen with you when coming to the Practice).
The Consultation will also establish relevant past medical and family history, including:

- Medical factors - illnesses, immunisations, allergies, hereditary factors, screening tests, current health
- Lifestyle factors - diet and exercise, smoking, alcohol and drug abuse.

Thank you for completing this form

For more information about the services we offer, please see our website:
www.westbridgfordmedicalcentre.co.uk