Text

Description automatically generated

**New Patient Questionnaire**

**Your named GP is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Date of Birth: / / Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(*By providing this email & signing this form I give my consent for the Practice to contact me via email for non-medical matters). Please see our privacy notice on the surgery website at* [*www.winscombebanwellsurgery.nhs.uk*](http://www.winscombebanwellsurgery.nhs.uk)



Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(By providing these contact number(s) & signing this form I give my consent for the Practice to contact me**via text including appointment reminders)*

**Patient Online Access** Would you like to register for online Patient Access? Yes: No:

If **YES**, your registration details will be email or posted to the address you have provided on this form.

If you are under 16 or wish to register on behalf of someone under the age of 16, a proxy access form must be completed, this is available from our reception team.

 **Ethnicity Group** (Please tick all the appropriate boxes) *This is not*

*compulsory but may help with your healthcare as some problems are more common in specific communities and knowing your origins may help with the early identification of some of these conditions.*

**White**

British  Irish  Other White  Prefer not to say

**Black**

African  British  Caribbean  Other Black

**Asian**

Indian  British  Pakistani  Bangladeshi  Chinese  Other Asian

**Mixed**

White & Black Caribbean  White & Black African  White & Asian  Other Mixed

Mixed multiple ethnic groups

A picture containing silhouette

Description automatically generated **Language/ Communication**

Main Spoken Language: \_\_\_\_\_\_\_\_\_\_\_\_\_Do you require an interpreter? Yes  No

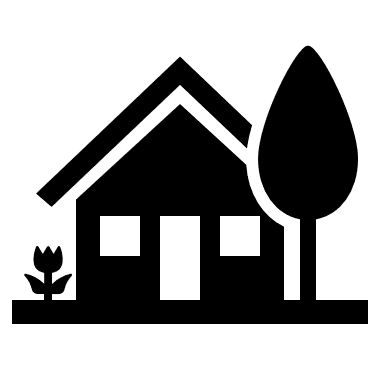
 **Are YOU a carer?** Please tick and explain *(A carer is someone who provides unpaid support to someone who could not manage without their help due to a physical or mental health condition, physical or learning disability, frailty, or substance misuse problems.)* Yes:  No:  Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you HAVE A CARER?** Yes:  No:  If yes, please provide their details:

Carers full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postcode: \_\_\_\_\_\_\_\_\_\_\_ Contact number(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Next of kin details**

Full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postcode: \_\_\_\_\_\_\_\_\_ Contact number(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Summary Care Record: This is an electronic record which contains information about the medicines you take, allergies you suffer from and any bad reactions to medicines you have had. Only healthcare staff involved in your care can see your Summary Care Record.

You can also opt to have **ADDITIONAL INFORMATION** added to you SCR. This includes significant medical history (past and present), reason for medication, anticipatory care information (such as information about the management of long term conditions), end of life care information AND immunisations.

**PLEASE TICK AS APPROPRIATE**

I wish to have a summary care record created **WITH CORE INFORMATION ONLY**

I wish to have a summary care record created **WITH ADDITIONAL INFORMATION** included

I **DO NOT** wish to have a summary care record created – **Please sign an opt out form at reception**

You can change your mind about your option at any time, simply by informing us at the Practice.



**What is your current smoking status?** Please tick and explain

Current smoker  How many Cigarettes/Cigars/Tobacco (in grams) per day \_\_\_\_\_\_\_

Would you like help to stop smoking Yes  No

Ex-smoker  When did you stop smoking \_\_\_\_\_\_\_\_\_\_\_ Never smoked

**Do you have a Disability or Special Communication Needs?** *Under the Equality Act 20110 you have a disability if you have physical or mental impairment that has a ‘substantial’ and ‘long term’ negative effect on your ability to do normal daily activities*

If yes, please provide details Yes: No:

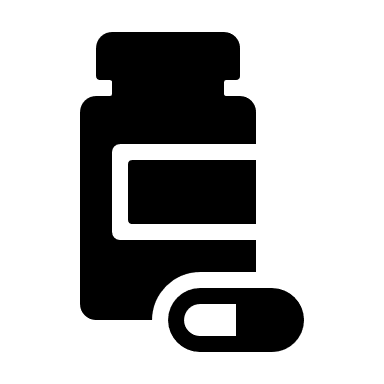
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Exercise** Do you take regular exercise? **YES/NO** If **YES**, what sort of exercise and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weight \_\_\_\_\_kg Height \_\_\_\_\_\_\_\_cm

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How many units of alcohol do you consume in a week?**  This is one unit of alcohol… | | | | | | |
| **Questions** | **Scoring System** | | | | | **Your**  **Score** |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink that contains alcohol? | Never | Monthly  or less | 2-4 per month | 2-3 per week | 4+ per week |  |
| How many 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  standard drinks on one occasion? | Never | < monthly | Monthly | Weekly | Daily |  |

|  |  |  |
| --- | --- | --- |
| Home1 with solid fill**Family History**  Is there any of the following in your close family (father, mother, brother, sister) | | |
|  | **YES/ NO** | **Family member** |
| Heart Disease, heart attack or angina - **Under the age of 60** |  |  |
| Heart Disease, heart attack or angina - **Over the age of 60** |  |  |
| Diabetes |  |  |
| Respiratory disease |  |  |
| Asthma |  |  |
| Hypertension |  |  |
| Epilepsy |  |  |
| Rheumatoid arthritis |  |  |
| Stroke |  |  |
| Cancer, if known please state which type of cancer |  |  |
| Other relevant history | | |
| **Clipboard All Crosses with solid fillAllergies**  Are you allergic to any substances, foods, or medicine? Yes No  If **yes,** please provide details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |



**Patient signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date form completed:** \_\_\_/\_\_\_/\_\_\_

**Medication** Do you take any regular medication? Yes No

If **yes** please provide details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prescriptions are sent electronically to a pharmacy of your choice. Please provide the details of your nominated pharmacy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **For practice use only:** | | | |
| **Date received into practice:** | | | |
| **Forms checked by (initials)** |  | **Type of photographic ID seen**  **Checked by (initials)** |  |
|  |
| **Registration completed on EMIS (initials & date)** | | | |
| **Patient questionnaire completed on EMIS (initials & date)** | | | |