Leatside Health Centre

New Patient Questionnaire (Adults)

Whilst we are waiting for your full medical records from your last doctor, it would help us if you could take the time to complete this questionnaire so that care is transferred as seamlessly as possible.

Please complete in **BLOCK CAPITALS** and tick relevant boxes.

- Please complete a separate form for each person to be registered.
- When registering please remember to bring photo ID & proof of address (please let us know if you do not have this). Each adult should bring their own ID and forms.

Do you have any special communication needs? ☐ Yes ☐ No

If yes: ☐ Sign Language ☐ Large Print ☐ Other

Personal Details

Full Name			
Date of Birth			
NHS No (if known)			
Home tel. number			
Mobile tel. number		**Can we contact you by SMS?**	☐ **Yes** ☐ **No**
E-mail address		**Can we contact you by email?**	☐ **Yes** ☐ **No**
Occupation			

Would you like Online Access to order prescriptions, book appointments and manage your health using online access? If yes, please provide an email address above, and we will email you with your log in details and instructions shortly after your registration at the practice is complete.	☐ **Yes** **I consent to the practice adding my details to the Patient Access system**	☐ **No** **I do not consent to the practice adding my details to the Patient Access system**

Next of Kin	
Name	
Tel. contact	
Relationship	

Medical & Social Background.

Do you need help with mobility/communication? **If No, please go to the next question**	☐ **Yes**	☐ **No**
Do you use any of the following mobility/communication aids: ☐ Wheelchair ☐ Walking aid ☐ Hearing Aid ☐ British Sign Language (BSL) ☐ Makaton Sign Language ☐ Lip reading ☐ Large print ☐ Braille ☐ Interpreter ☐ Other (please specify)		

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Are you currently housebound?	□ **Yes**	□ **No**
If yes, is this temporary or permanent?	□ **Temp**	□ **Perm**
If housebound, please provide details below:		

Please give information about any serious illnesses, operations, or injuries you have had in the past. If none, please go to next question

Condition:	Year Diagnosed:	Ongoing: □ Yes □ No

Please provide details of any medication you take:

Medication Name	Dosage	Frequency

Please nominate a Pharmacy, where you would like your medication to be sent	

Please give details of any allergies or sensitivities you may have to medication/food:

Female patients only Do you think you may be pregnant?	□ **Yes**	□ **No**
Have you had a mammogram (aged 50+)?	□ **Yes**	□ **No**
Which method of contraception (if any) are you using at present?		

Patients aged 25 – 64 eligible for cervical screening i.e. women and trans men with a cervix	
Have you had a smear in the past?	□ **Yes** □ **No**
Date of last smear, if applicable	
Outcome of last smear, if applicable	

Have any close relatives (father, mother, sister, brother only), ever suffered from any of the following (please indicate who in the boxes)

Heart attack	Stroke	Diabetes	High blood pressure	Asthma	Glaucoma	Cancer

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Do you have a social worker and/or support worker? If no please go to next question	□ **Yes**	□ **No**
If yes, please tell us their name and who they work for:		

Are you a carer for someone at home? □ **Yes** □ **No** Please let us know if you are looking after someone who is ill, frail, disabled, has mental health/emotional support needs or substance misuse problems:		
Would you like to be added to our carer's list, and consent to helpful information being sent to you?	□ **Yes**	□ **No**
Do you have a carer? □ **Yes** □ **No** If yes, please tell us their name and address:		
Are you happy for us to contact your carer?	□ **Yes**	□ **No**

Lifestyle

Do you smoke?				□ **Yes**	□ **No**
If yes, do you smoke:	Cigarettes □		Cigars □	Pipe □	
How many do you smoke daily?	1/day □	1-9/day □	10-19/day □	20-39/day □	40+/day □
If you smoke a pipe, how many ounces a week?					
Are you an ex-smoker?				□ **Yes**	□ **No**
If yes, when did you give up?					

Do you drink alcohol?				□ **Yes**	□ **No**
How often do you drink?	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 drink on a typical day?	1-2 □	3-4 □	5-6 □	7-8 □	10+ □
How often do you have 6 or more standard drinks on one occasion?	Never □	Less than monthly □	Monthly □	Weekly □	Daily or almost daily □

Please enter your height and weight:	**Height:**	**Weight:**

Religion:

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

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Ethnic Origin (select one):

☐ White (UK) ☐ White (Irish) ☐ White (Other) ☐ Caribbean ☐ African
☐ Asian ☐ Other Mixed Background ☐ Indian/Brit Indian ☐ Pakistani/Brit Pakistani
☐ Bangladeshi/Brit Bangladeshi ☐ Other Asian Background ☐ Other Black Background
☐ Chinese ☐ Other (please specify) _____ ☐ Decline to state

main or 1st language spoken/understood (select one)

☐ English ☐ Hindi ☐ Gujurati ☐ Urdu ☐ Bengali ☐ Punjabi ☐ Polish ☐ Ukrainian ☐ French ☐ German ☐ Spanish ☐ Other (please specify) _____
☐ Decline to state

Data Sharing and Consent Choices

To maintain continuity of clinical care, we upload certain medical information so that it is available to other healthcare organisations (e.g. Emergency Departments). A summary care record (SCR) is an electronic summary of key health information. It will hold limited essential information derived initially from your GP record. This will include medication, adverse reactions, and allergies. If you wish to know more information regarding the system and the benefits please ask reception. Alternatively, visit the website: https://digital.nhs.uk/services/summary-care-records-scr/summary-care-records-scr-information-for-patients

Would you like to: Opt in: ☐ Opt out: ☐

Please visit our website or ask a member of staff if you would like to see the Practice Privacy Statement.
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Name of person Completing form: _____ **Date**_____
(Please print)

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For Official Use

ID Seen	Birth Certificate ☐
	Passport ☐
	Driving Licence ☐
	Other ☐ Please specify…….
ID seen by whom	(Print Name)
All required information supplied ☐ Registration accepted ☐ Clinical system updated ☐	
EMIS ID:	
Notes:	

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