New Patient Questionnaire (Aged 17 and Over)

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			
Preferred Title e.g. Mr, Miss, Mrs, Mx etc		**If you would like us to record your preferred pronouns, please give details**	
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			

Please give details of your Next of Kin below:

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)		
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:		

Pregnancy & Contraception (if applicable) Do you think you may be pregnant?	□ **Yes**	□ **No**
Which method of contraception (if any) are you using at present? (Leave blank if not applicable)		
Breast Screening (if applicable)		
Have you had a mammogram (aged 50+)?	□ **Yes**	□ **No**
Patients aged 25 – 64 who are eligible for cervical screening (smear test)		
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

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 vape/use electronic cigarettes?				□ **Yes**	□ **No**
If so, when did you start vaping/using electronic cigarettes?					
Do you drink alcohol?				□ **Yes**	□ **No**
How often do you have a drink containing alcohol?	Never □	Monthly or less □	2-4 times per month □	2-3 times per week □	4+ times per week □
How many units of alcohol do you drink 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 units if female, or 8 or more if male on a single occasion in the last year?	Never □	Less than monthly □	Monthly □	Weekly □	Daily or almost daily □
Please enter your height and weight:	**Height:**		**Weight:**		

Ethnic Group (select one):
White - □ English/Welsh/Scottish/Northern Irish/British □ Irish □ Gypsy or Irish Traveller □ Other white background (please describe)_____
Mixed/Multiple ethnic groups - □ White and Black Caribbean □ White and Black African □ White and Asian □ Any other Mixed/Multiple ethnic background (please describe) _____
Asian/Asian British - □ Indian □ Pakistani □ Bangladeshi □ Chinese □ Any other Asian background (please describe) _____
Black/African/Caribbean/Black British - □ African □ Caribbean □ Any other Black/African/Caribbean background (please describe) _____
Other ethnic group - □ Cornish □ Arab □ Any other ethnic group (please describe)_____
_____

Religion:

□ No religion □ Christian (including Church of England, Catholic, Protestant and all other Christian denominations □ Buddhist □ Hindu □ Muslim □ Sikh
□ Jewish □ Any other religion (please describe) _____

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

□ English □ Hindi □ Gujurati □ Urdu □ Bengali □ Punjabi □ Polish □ Ukrainian □ French
□ German □ Spanish □ Other (please specify) _____

Data Sharing and Consent Choices

To maintain continuity of clinical care, we upload certain medical information so that it can be viewed by other healthcare organisations who are directly involved in your care, e.g. hospital Emergency Department. A summary care record (SCR) is an electronic summary of key health information and contains information about your medication, allergies and adverse reactions, and other information such as significant illnesses and health problems, operations and vaccinations. An SCR is automatically created for you, but you can express a preference about what information is included or you can choose not to have one. For more information, visit the website: https://digital.nhs.uk/services/summary-care-records-scr/summary-care-records-scr-information-for-patients or speak to a member of staff at the surgery.

For more information about how the surgery handles your personal information, please visit our website and view our Privacy Policy. Alternatively, please speak to a member of staff at the surgery.
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Online Services

The NHS App allows you to access a range of NHS services online, including ordering repeat prescriptions and viewing your GP records. To access the NHS App, you will need to set up an NHS login and prove who you are. Your NHS App then securely connects to information from your GP surgery. For more information, please search for the NHS app online. You can also speak to a member of a staff at the surgery about other ways to access NHS services online.

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:	