# New Patient Questionnaire (Aged 18 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.

## 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** | |
| **How would you describe your gender identity? (The answer does not have to match the sex registered at birth)** | **Male** ☐ **Female** ☐ **Non-binary** ☐ **In another way** ☐ | | |
| **Is your gender identity the same as the sex registered at birth?** | **Yes** ☐ **No** ☐ | | |
| **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 to you** | |

## Medical & Social Background.

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|---|---|---|
| **Q1 Do you need help with mobility/communication?**<br>**If No, please go to Q2** | **Yes** ☐ | **No** ☐ |
| Do you use any of the following mobility/communication aids:<br>Wheelchair ☐ Walking aid ☐ Hearing Aid ☐ British Sign Language (BSL) ☐<br>Makaton Sign Language ☐ Lip reading ☐ Large print ☐ Braille ☐ Interpreter ☐<br>Other ☐ please give details below | | |
| **Q2 Are you currently serving in the Armed Forces as a Regular?** | **Yes** ☐ | **No** ☐ |

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| **Q3 Are you currently serving in the Armed Forces as a Reserve?** | **Yes** ☐ | **No** ☐ |
| **Q4 Are you an Armed Forces Veteran?** | **Yes** ☐ | **No** ☐ |
| **Q5 Are you an immediate relative of a currently serving Regular or Reserve?** | **Yes** ☐ | **No** ☐ |

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| **Q6 Are you currently housebound?** | **Yes** ☐ | **No** ☐ |
| **If yes, is this temporary or permanent?** | **Temporary** ☐ | **Permanent** ☐ |

**Q7 Please give information about any serious illnesses, operations, or injuries you currently have or have had in the past. If none, please go to Q8.**

| Condition: | Year Diagnosed: | Please state if ongoing |
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**Q8 Please provide details of any medication you take (if none, please go to Q9):**

| Medication Name | Dosage | Frequency |
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| **Please nominate a Pharmacy, where you would like your medication to be sent** | |

**Q9 Please give details of any allergies or sensitivities you may have to medication/food:**

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| **Q10 Pregnancy (if applicable).** Do you think you may be pregnant? | ☐ **Yes**<br>☐ **No** | If yes, what is your due date? ____/____/____ |
| **Q11 Contraception (if applicable).** Which method of contraception (if any) are you using at present? (Leave blank if not applicable) | | |
| **Q12 Breast Screening (if applicable).** Have you had a mammogram (aged 50+)? | | **Yes** ☐ **No** ☐ |
| **Q13 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** | | |

**Q14 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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| **Q15 Do you have a social worker and/or support worker?** | **Yes** □ | **No** □ **(go to Q16)** |
| If yes, please tell us their name and who they work for: | | |
| **Q16 Are you a carer for someone at home? Yes** □ **No** □ **(go to Q17)**<br>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: | | |
| **Q17 Do you have a carer?** □ **Yes** □ **No (go to Q18)**<br>If yes, please tell us their name and address: | | |
| **Are you happy for us to contact your carer?** | **Yes** □ | **No** □ |

## Lifestyle

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| **Q18 Do you smoke?** | | | **Yes** □ | **No** □ **(go to Q19)** | |
| 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?** | | | | | |

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| **Q19 Are you an ex-smoker?** | **Yes** □ | **No** □ **(go to Q20)** |
| If yes, when did you give up? | | |

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| **Q20 Do you vape/use electronic cigarettes?** | **Yes** □ | **No** □ **(go to Q21)** |
| **If yes, when did you start vaping/using electronic cigarettes?** | | |

| **Q21 Do you drink alcohol?** | **Yes** □ **please give details below** | | | **No** □ **(go to Q22)** | |
|---|---|---|---|---|---|
| **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 □ |

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| **Q22 Please enter your height and weight:** | **Height:** | **Weight:** |

**Religion (please select one)**:
No religion □ Christian (including C of E, Catholic, Protestant and all other Christian denominations □ Hindu □ Buddhist □ Muslim □ Sikh □ Jewish □ Any other religion □ (please describe)

**Ethnic Group (please 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)_____
_____

**Main or 1st language spoken/understood (please 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**

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|---|---|
| ID Seen | Birth Certificate □ |
| | Passport □ |
| | Driving Licence □ |
| | Other □<br><br>Please specify |
| ID seen by whom | (Print Name) |
| All required information supplied □ Registration accepted □ Clinical system updated □ | |
| EMIS ID: | |
| Notes: | |