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**NEW PATIENT QUESTIONNAIRE**

In order for us to provide you with good quality care it would be helpful if you could complete this questionnaire regarding your personal details and medical history.

**AS A NEW PATIENT, WE REQUIRE FULL IDENTIFICATION:**

**PASSPORT** □ **DRIVING LICENCE (both card and paper)** □ **BIRTH CERTIFICATE** □

***OFFICE USE ONLY: NEW PATIENT ALLOCATED GP:*** □ ***NEW PATIENT INFORMED OF GP:*** □

**PERSONAL DETAILS - Please complete all boxes to ensure full registration**

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| Full Name: | Date of Birth: |
| Address:  |
| Phone No: | Mobile No.: |
| Email Address: | Place of Birth: |
| Marital Status: | Height: |
| Ethnicity Group: | Weight: |
| Details of Next of Kin: |
| Main Spoken Language: |
| Occupation: |
| Have you ever served in the forces?: |

**MEDICAL HISTORY**

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| **DISEASE** | **Yes/No** | **On medication (please state)** | **Date of Last Review** |
| **Respiratory** |  |
| Asthma/COPD |  |  |  |
| Breathing Difficulties |  |  |  |
| **Cardiac** |  |
| Heart Attack/Stroke |  |  |  |
| Blood Pressure |  |  |  |
| Irregular Heartbeat |  |  |  |
| Other |  |  |  |
| **Diabetes** |  |  |  |
| **Epilepsy** |  |  |  |
| **Cancer** |  |  |  |
| **Thyroid Disease** |  |  |  |
| **Kidney Disease** |  |  |  |
| **Mental Health Problems** |  |  |  |
| **Cervical Smear (Females)** |  |  |

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| Have you had any serious illnesses or operations? (Please state) |
| Please tell us if you have any known allergies (i.e. penicillin, aspirin, plasters, nuts, bee stings etc.) |
| Have you had your Blood Pressure checked in the last 5 years? Yes/No (If no please arrange an appointment) |
| Are you a carer? Yes / No  | If yes, who? |
| Do you have a carer? Yes / No  | If yes, who? |
| Do you have Social Services help? Yes / No  |
| Do you have any disabilities? (Please state) |

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| Do you smoke now? Yes / No  | Have you ever smoked? Yes / No  |
| How many do you smoke per day? |
| Are you exposed to smoke at home? Yes / No  | Are you exposed to smoke at work? Yes / No  |

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| **Questions (Part 1)** | **Scoring System** | **Your Score** |
| **0** | **1** | **2** | **3** | **4** |
| 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 have you had 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 |  |
| **If you score 5 or above, please complete the second part of the questionnaire** |
| **Questions (Part 2)** | **Scoring System**  | **Your Score** |
| **0** | **1** | **2** | **3** | **4** |
| How often during the last year have you found that you were not able to stop drinking once you had started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you failed to do what was normally expected from you because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you had a feeling of guilt or remorse after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you been unable to remember what happened the night before because you had been drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| Have you or somebody else been injured as a result of your drinking?  | No |  | Yes, but not in the last year |  | Yes, during the last year |  |
| Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?  | No |  | Yes, but not in the last year |  | Yes, during the last year |  |
| Do you have a varied diet including milk, meat, vegetables and fruit? Yes/No |

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| How many times per week do you exercise?  |
| How many minutes do you exercise for at a time?  |

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| **Is there any of the following in your family (Father, Mother, Brother or Sister) before age 65?** |
| Heart Disease (heart attack, angina) Yes / No | Which family member?  |
| Stroke Yes / No | Which family member? |
| Cancer Yes / No | Which family member?  |
| Site of Cancer |

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| **What medicines do you take?** |
| *A repeat prescription counterfoil from your previous doctor would be useful, please attach it to this questionnaire if you have one* |
| **Please circle below where you would prefer to collect your prescription from:**  |
| Barn Pharmacy | High Street Pharmacy | Peacemarsh Pharmacy | Other (please state) |

For information about Electronic Prescribing please contact the pharmacy.

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| ***We undertake annual reviews including medication reviews and any blood tests during your birth month****.*  |

**Summary Care Record**

The NHS is changing the way your health information is stored and managed. The NHS Summary Care record is an electronic record of important information about your health. At this Practice we support Summary Care Records and as a patient you have a choice:

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| Yes I would like a Summary Care Record □No I do not want a Summary Care Record □ |

**You are free to change your decision at any time by informing your GP practice. For more information contact the Health and Social Care Information Centre on 0300 303 5678.**

**Accessible Information Standard**

The Accessible Information Standard was approved in June 2015. The aim of this is to make sure that patients with a disability, impairment or sensory loss receive information that they can access and understand. If you have any information or communication needs, please state these below in the comment box and how we can try to meet these needs for you.

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| **Comment Box*****OFFICE USE ONLY: Medical records coded*** □ |

**Website:** [www.gillinghamsurgery.co.uk](http://www.gillinghamsurgery.co.uk)

We are able to offer an online facility via our website to book appointments, request repeat prescriptions and make general enquiries. To use this facility you will need to be issued with a unique login username and password.

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| Please register me for the Online Appointment Booking Service Yes / No |

**You will need to collect your unique login username and password details from Reception.**

**SMS Text Reminders**

We are also able to offer SMS text reminders to your mobile phone. To receive a reminder for your next appointment we need to register you for this service. This is free and confidential.

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| Please register me for the SMS Text Reminder Service Yes / No **Mobile No.**  |

**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 experience, views and ideas of general practice. By joining this group you will receive regular newsletters and emailed surveys and updates. This will help the Practice plan ahead to offer the widest range of services possible.

**If you would prefer not to be part of the Patient Participation Group, please tick this box** □

Thank you for taking the time to complete this questionnaire