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| *Surg.gif* | | | | | | | | | ID Checked: | | | (staff initials) |
|  | | | | | | | | | Passport | | |  |
|  | | | | | | | | | Drivers Licence | | | |
|  | | | | | | | | | ID Card | | | |
|  | | | | | | | | | Other | | | |
| BOURN SURGERY NEW PATIENT QUESTIONNAIRE | | | | | | | | | | | | |
| All questions contained in this questionnaire are strictly confidential  and will become part of your medical record. | | | | | | | | | | | | |
| Surname: | | First name(s): | | | | M  F | | DOB: | |  | | |
|  |  | | | | | | | | | | | |
| Address: Occupation:  Children of school age (U16): | | |  | | Name of School: | | | | | |  | |
| Who has parental responsibility for the child (U16) and relationship to the child: | | | | | | | | | | | | |
| Home Telephone:Mobile Telephone: | | |  | | 🞎 I am happy for the surgery to contact me by text  (*we will not contact you unnecessarily)*  *Remember to tell us if you change your mobile number*  🞎 I do not wish to be contacted by text | | | | | | | |
| E-mail address: 🞎 I am happy for the surgery to contact me by e-mail | | | | | Language: 🞎 I can speak English  Main language if not English …………………………………….. | | | | | | | |
| Ethnicity *(please tick as appropriate)* 🞎 White British  🞎 White Other  🞎 White & Black Caribbean  🞎 White & Black African | | | | 🞎 White and Asian  🞎 Pakistani  🞎 Bangladeshi  🞎 Caribbean  🞎 Indian | | | 🞎 Chinese  🞎 Decline to say | | | | | |
| Next of Kin: Name:  Address:  Telephone Number:  Relationship: | | | | | | | | | | | | |
| **Carers/Foster Care/ Social Workers**  A carer is anyone who provides day to day help to someone who would not easily manage without them. This would not include a typical parent caring for their child or a professional carer, but may include someone who cares for a child with particular needs. Please let us know if you have fostering arrangements in place.  I have a carer  Name of carer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship to you \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I am a carer  I would like to receive information about services | | | | | | | | | | | | |
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|  | | | | | | | | | | | | |
| PERSONAL HEALTH HISTORY | | | | | | | | | | | | |
| Medical History - please also list any operation/serious medical problems? | | | | | | | | | | | | |
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| Medication – Please list any medication you currently receive from your doctor | | | | | | | | | | | | |
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|  | | | | | | | | | | | | |
| Allergies – Please list any known allergies | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| Vaccinations | | | | | | | | | | | | |
| MMR 1st Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  MMR 2nd Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  Meningitis C Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  Pneumococcal Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ | | | | | | | | | | | | |
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| WOMEN ONLY | | | | |
| **25 yr old and over** | | | | |
| Age at onset of menstruation/period: | | | | |
| Date of last menstruation/period: | | | | |
| Period every       days | | | | |
| My last cervical smear test was on:  I have never had a cervical smear test  I had a hysterectomy on: | | | | |
| Heavy periods, irregularity, spotting, pain, or discharge? |  | Yes |  | No |
| Number of pregnancies       Number of live births | | | | |
| Are you pregnant or breastfeeding? |  | Yes |  | No |
| **Under 25yr olds** *Smears are not usually recommended under 25yr but if you have had one please complete the above section.* | | | | |
| **15 – 24yr olds ONLY - Chlamydia Screening**  *Chlamydia is an infection which can be caught by having sex. People with it do not usually notice anything wrong, but it can lead to problems with fertility later in life. We are trying to treat everyone who has the infection. Sincere there are usually no symptoms, we need to test everyone at risk even if they think they are well. This is a simple urine test which you can do yourself.*  **Please ask reception for a test.** | | | | |

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| Online Services |
| You can order repeat prescriptions, make appointments and view your summary care records.  On-line services is available to any patient aged 16 and over. Proxy access to Parents stop when the child reaches 11.  Please see patient-on-line service link on the website.  I would like to sign up for SystmOnline |

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| HEALTH HABITS AND PERSONAL SAFETY | | | | | | | | |
|  | | | | | | | | |
| Estimate | Height | | | | | | | |
| Weight | | | | | | | |
| Alcohol | Do you drink alcohol? | | | |  | Yes |  | No |
| How often do you have a drink that contains alcohol?  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 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  Less than monthly  Monthly  Weekly  Daily or almost daily | | | | | | |  |
| Are you concerned about the amount you drink? | | | |  | Yes |  | No |
| Have you considered stopping? | | | |  | Yes |  | No |
| Have you ever experienced blackouts? | | | |  | Yes |  | No |
| Are you prone to “binge” drinking? | | | |  | Yes |  | No |
| Tobacco | Do you use tobacco? | | | |  | Yes |  | No |
| Cigarettes – pks./day | | Chew - #/day | Pipe - #/day | Cigars - #/day | | | |
| # of years | Or year quit | | | | | | |
|  | *If you would like help to give up smoking please speak to either your GP or make an appointment to see the practice nurse.* | | | | | | | |
|  |  | | | | | | | |
|  |  | | | | | | | |
| Personal Safety | Do you live alone? | | | |  | Yes |  | No |
| Do you have frequent falls? | | | |  | Yes |  | No |
| Do you have any self-identified communication needs for example lip reading, or need for larger print? | | | |  | Yes |  | No |
| Do you have vision or hearing loss? | | | |  | Yes |  | No |
| Do you have an Advance Directive and/or Living Will? | | | |  | Yes |  | No |

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| FAMILY HISTORY | | |
| Family Member(s) and age of diagnosis | |  |
| Breast Cancer Cancer (other)  Dementia  Hypertension  Asthma | | Heart Attack/Disease  Mental Health  Stroke  Diabetes  Other |
| SUMMARY CARE RECORDS  *The NHS is creating centralized electronic records for all patients. The current proposal is that this will only contain information about any medicines you are taking, allergies you have and any bad reactions that you have had.*  *Giving healthcare staff access to this information can help prevent mistakes being made when caring for you in an emergency or when the surgery is closed. Staff will ask you if they wish to access your Summary Care Record.*  *If you would like further information*  [*http://www.nhscarerecords.nhs.uk/summary*](http://www.nhscarerecords.nhs.uk/summary)  *OR call the information line on 0300 1233020*  *I am happy to have a Summary Care Record*  YES  NO *(tick as appropriate)*  *Signed ……………………………………………………………………*  The NHS will create a  Summary Care Record  For you unless you tell us not to do so | SHARING IN AND OUT  *Sharing OUT – this controls whether your information recorded at this practice can be shared with other healthcare services.*  *Sharing IN – This determines whether or not this practice can view information in your records that has been entered by other services who are providing care for you – or who may provide care for you in the future.*  *SHARING OUT*  *I would like my health record at this practice to be shared with other healthcare services providing care for me*  YES  NO  *SHARING IN*  *I would like this practice to be able to view information in my health record that has been recorded by other healthcare services.*  YES  NO *(tick as appropriate)*  *Signed ……………………………………………………………………* | |

The surgery offers a health check with a GP for all new patients, please contact reception to book your appointment on 01954 719313 or 01954 719469.