NEW PATIENT QUESTIONNAIRE

Full Name			Title	
Date of Birth		Sex	Male ☐ Female ☐	
Mobile number:		Email address:		
Height (ft & ins or cms)		Weight (st & lbs or kgs)		
Ethnicity:		Occupation:		
1st Language:	**Do you need an interpreter?**	Do you consent to be contacted by email? YES / NO Do you consent to be contacted by text? YES / NO		
Next of Kin/ Emergency Contact Number:				
Carers information	Do you need/ have anyone who looks after you and your daily needs as a Carer? YES / NO If 'Yes', would you like them to deal with your health affairs here? YES / NO Do you care for anyone else? YES / NO If 'Yes', ask the receptionist about Carers support.			

Smoking – Tick the boxes that apply to you below

Do you smoke?	☐ Never smoked ☐ Light Ex-smoker ☐ Moderate Ex-smoker ☐ Heavy Ex-smoker If ex-smoker, when did you stop smoking? …………………………………………………………… ☐ Current Smoker How much do you smoke per day? …………………………………………………………… ☐ Would you like some advice to help you stop smoking?

Alcohol - Tick the boxes that apply to you and add up the points to find your total. If you score **5 or more**, please complete the **questionnaire over the page**

How often do you have a drink that contains alcohol?	☐ Never *(0 points)* ☐ Monthly or less *(1 point)* ☐ 2 – 4 times per month *(2 points)* ☐ 2 – 4 times per week *(3 points)* ☐ 4 + times per week *(4 points)*
How many standard alcoholic drinks do you have on a typical day when you are drinking?	☐ 1 – 2 *(0 points)* ☐ 3 – 4 *(1 point)* ☐ 5 – 6 *(2 points)* ☐ 7 – 9 *(3 points)* ☐ 10 + *(4 points)*
How often do you have 6 or more standard drinks on one occasion?	☐ Never *(0 points)* ☐ Monthly or less *(1 point)* ☐ 2 – 4 times per month *(2 points)* ☐ 2 – 4 times per week *(3 points)* ☐ 4 + times per week *(4 points)*
Total Score	……………………….. points

Do you OR an immediate member of your family suffer from any of the following conditions?

	No	Yes, I do	Yes, a family member does (please specify who):
Please tick	✓	✓	✓
Asthma			
Diabetes			
Heart Disease			
Stroke / Mini Stroke / Transient Ischaemic Attack (TIA)			

Do you have any other serious illnesses, health problems, or have you had any operations? (please give details)

Please list any pending hospital appointments you may have: (Please advise the hospital that you have changed GP Practices)

Please list any repeat medication you are taking:

Please list any allergies you have:

P.T.O

Female patients only:

Date of last smear		Date of last breast X-ray	
Result		Result	

TO BE COMPLETED FOR CHILDREN ONLY
Please give dates of all **Childhood Immunisations** and/or indicate if the child has not been immunised.

Age	Immunisation								
	Diphtheria Tetanus Pertussis Polio *(DTaP/IPV)*	Hib	Pneumococcal *(PCV)*	Meningitis B *(MenB)* (from 01.09.15)	Rotovirus	Meningitis C *(MenC)*	MMR	Diphtheria Tetanus Polio *(DTaP)*	MenC ACWY
8 weeks									
12 weeks									
16 weeks									
12-13 months									
From 3.5 yrs									
14-18 yrs									

	1st Dose	2nd Dose	3rd Dose
Girls aged 12-13 years - HPV			

Alcohol consumption

	Scoring system					
Questions	**0**	**1**	**2**	**3**	**4**	**Your score**
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	

Total score:

Consent for Summary Care Record:

A Summary Care Record is an electronic record which contains information about the medicines you take, allergies you suffer from and any bad reactions to medicines you have had. Should you decide to have a Summary Care Record, having this information stored in one place makes it easier for healthcare staff in various locations across the UK to treat you in an emergency, or when your GP Practice is closed.

Your Summary Care Record will also include your name, address, date of birth and your unique NHS number to help identify you correctly.

You may want to add other details about your care to your Summary Care Record. This will only happen if you ask for the information to be included. You should discuss your wishes with the healthcare staff treating you.

Further information on the subject is available as a booklet from reception. This booklet is also available in other languages if required.

Do you give consent to your Summary Care Record being uploaded to the national spine?

Yes ☐ No ☐

If signing on behalf of a child please print their name clearly:

PRINT NAME (BLOCK CAPITALS): ______________________________

Relationship to child ___________________________

Signature: _______________________________

Patient Online - Registration Form:

You can now use the internet to book appointments with a GP, request repeat prescriptions for any medications you take regularly and look at your medical record online. To register for this service you must complete the form and bring in ID to show the receptionist. Once your access has been approved by a GP, your login details will be emailed to you.

I wish to have access to the following online services (tick all that apply):

Booking appointments ☐ Requesting repeat medication ☐ Accessing my full medical record ☐

I wish to access my medical record online and understand and agree with each statement (please tick):

I will be responsible for the security of the information that I see or download ☐

If I choose to share my information with anyone else, this is at my own risk ☐

I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement ☐

If I see information in my record that it not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible ☐

For practice use only:

Identity verified through (tick all that apply)	Vouching with information in record ☐ Photo ID ☐ Proof of residence ☐	Name of verifier:	Date:

P.T.O

LATENT TB (TO BE COMPLETED BY ADULTS AGED 16 – 35 YEARS AT TIME OF REGISTRATION)

TB is more common in the countries shown below.

Were you born in one of these countries? Yes / No
Date of **first** entry to the UK: ________________

Since 2011 have you:
Visited/ stayed in any of these countries for 6 months or longer or lived in one of these countries? Yes / No
Date of entry to UK following visit: ________________

If yes to either of the above please tick the relevant countries.

Country	Please tick below	Country	Please tick below
Afghanistan		Liberia	
Angola		Madagascar	
Bangladesh		Malawi	
Benin		Mali	
Bhutan		Marshall Islands	
Botswana		Mauritania	
Burkina Faso		Mauritius	
Burundi		Micronesia	
Cote d'Ivoire		Mongolia	
Cabo Verde		Mozambique	
Cambodia		Myanmar	
Cameroon		Namibia	
Central African Republic		Nepal	
Chad		Niger	
Comoros		Nigeria	
Republic of the Congo		Pakistan	
DRP Korea		Papua New Guinea	
DR Congo		Philippines	
Djibouti		Republic of Moldova	
Equatorial Guinea		Rwanda	
Eritrea		Sao Tome and Principe	
Ethiopia		Senegal	
Gabon		Seychelles	
Gambia		Sierra Leone	
Ghana		Somalia	
Greenland		South Africa	
Guinea		South Sudan	
Guinea-Bissau		Swaziland	
Haiti		Timor-Leste	
India		Togo	
Indonesia		Tuvalu	
Kenya		Uganda	
Kiribati		Tanzania	
Laos PDR		Zambia	
Lesotho		Zimbabwe	

Sign: ______________________________ **Date:** ________________________

Thank you for completing this form.

For more information about the services we offer, please refer to your new patient pack, or visit our website: west4gps@nhs.net