**AWBURN HOUSE MEDICAL PRACTICE**

**NEW PATIENT QUESTIONNAIRE**

|  |  |
| --- | --- |
| **SURNAME:** | **FIRST NAME:** |
| **DATE OF BIRTH:****WHICH OF THE FOLLOWING BEST DESCRIBES HOW YOU THINK OF YOURSELF?*** **FEMALE (INCLUDING TRANS WOMEN)**
* **MALE (INCLUDING TRANS MEN)**
* **NON-BINARY**
* **IN ANOTHER WAY**

**IS YOUR GENDER IDENTITY THE SAME AS THE GENDER YOU WERE GIVEN AT BIRTH?*** **YES**
* **NO**
 | **WHICH OF THE FOLLOWING OPTIONS BEST DESCRIBES YOU:*** **HETEROSEXUAL/STRAIGHT**
* **LESBIAN/GAY**
* **BISEXUAL**

**HOW WOULD YOU LIKE TO BE REFERRED TO:*** **MR**
* **MRS**
* **MISS**
* **MS**
* **OTHER – PLEASE STATE**
 |
| **IF YOU ARE COMPLETING THIS FOR A CHILD, WHO HAS PARENTAL RESPONSIBILITY?****NAME OF SCHOOL**  | **PARENTAL RESPONSIBILITY:****SCHOOL:** |
| **PREVIOUS SURNAME:** | **CONTACT DETAILS:****HOME PHONE:****WORK PHONE:****MOBILE PHONE:****EMAIL:****WHICH OF THE ABOVE IS YOUR PREFERRED METHOD OF CONTACT?** |
| **ETHNIC ORIGIN (eg White British)** | **PREFERRED FIRST LANGUAGE:** |
| **MARITAL STATUS: Married/Single/Divorced etc** | **NUMBER OF CHILDREN AND AGES:** |
| **ARE YOU A CARER:** | **DO YOU HAVE A CARER:** |
| **DO YOU HAVE ANY INFORMATION/COMMUNICATION NEEDS RELATING TO A DISABILITY, IMPAIRMENT OR SENSORY LOSS?** | **YES/NO****IF YES, PLEASE STATE:** |

**MEDICAL HISTORY**

|  |  |
| --- | --- |
| **SMOKER/EX SMOKER/NEVER SMOKED:****If smoker, would you like help to stop? YES/NO** | **ALCOHOL:****UNITS PER WEEK:** |
| **DO YOU TAKE REGULAR EXERCISE?*** **DAILY**
* **WEEKLY**
* **NEVER**
* **OTHER – PLEASE STATE**
 | **DO YOU SUFFER WITH ANXIETY AND OR DEPRESSION?** |
| **DO YOU HAVE ANY ALLERGIES?****If yes, please list** | **ARE YOU TAKING ANY REGULAR MEDICATION?****If yes, please attach a list** |

**DO YOU OR A MEMBER OF YOUR FAMILY SUFFER FROM ANY OF THE FOLLOWING:**

|  |  |
| --- | --- |
| **High blood pressure** | **YES/NO** |
| **Depression/anxiety** | **YES/NO** |
| **Heart disease** | **YES/NO** |
| **Stroke** | **YES/NO** |
| **Diabetes** | **YES/NO** |
| **Epilepsy****Asthma** | **YES/NO****YES/NO** |
| **Other** |  |

**IS THERE ANY OTHER INFORMATION YOU WOULD LIKE YOUR GP TO BE AWARE OF?**

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**PHQ-9**

**Over the last 2 weeks, how often have you been bothered by any of the following problems?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Not at all** | **Several days** | **More than half the days** | **Nearly every day** |
| **Little interest or pleasure in doing things** | **0** | **1** | **2** | **3** |
| **Feeling down, depressed or hopeless** | **0** | **1** | **2** | **3** |
| **Trouble falling or staying asleep, or sleeping too much** | **0** | **1** | **2** | **3** |
| **Feeling tired or having little energy** | **0** | **1** | **2** | **3** |
| **Poor appetite or overeating** | **0** | **1** | **2** | **3** |
| **Feeling bad about yourself, or that you are a failure or have let yourself or your family down** | **0** | **1** | **2** | **3** |
| **Trouble concentrating on things, such as reading the newspaper or watching television** | **0** | **1** | **2** | **3** |
| **Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual** | **0** | **1** | **2** | **3** |
| **Thoughts that you would be better off dead or of hurting yourself in some way** | **0** | **1** | **2** | **3** |

**For office coding – total score**

**GAD-7**

**Over the last 2 weeks, how often have you been bothered by the following problems?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Not at all** | **Several days** | **More than half the days** | **Nearly every day** |
| **Feeling nervous, anxious or on edge** | **0** | **1** | **2** | **3** |
| **Not being able to stop or control worrying** | **0** | **1** | **2** | **3** |
| **Worrying too much about different things** | **0** | **1** | **2** | **3** |
| **Trouble relaxing** | **0** | **1** | **2** | **3** |
| **Being so restless that it is hard to sit still** | **0** | **1** | **2** | **3** |
| **Becoming easily annoyed or irritable** | **0** | **1** | **2** | **3** |
| **Feeling afraid as if something awful might happen** | **0** | **1** | **2** | **3** |

**For office coding – total score**

**ALCOHOL**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Questions** | **0** | **1** | **2** | **3** | **4** | **score** |
| **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** |  |

**Scoring: A total of 5+ indicates increasing or higher risk drinking. An overall total score of 5 or above is Audit-C positive, continue with the next set of questions.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Questions** | **0** | **1** | **2** | **3** | **4** | **Score** |
| **How often during the last year have you found that you were unable to stop drinking once 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 had a feeling of guilt or emorse 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** |  |
| **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** |  |
| **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 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** |  |

**Score: 0 to 7 Lower risk, 8 to 15 Increasing risk, 16 to 19 Higher Risk, 20+ Possible dependence.**

**If you have told us you are a carer for someone, we will add you to our carers list and can offer you support and information by referring you to the local carers centre. *We will only do this with your permission.***

**Would you like us to refer you to our local carers centre? Yes/No**

**Awburn House offers a text messaging service to remind you of your appointments and any health checks due. Please indicate below if you wish to receive these messages.**

**I do/do not agree to receiving text messages from my practice.**

**Awburn House have a ‘Virtual Patient Participation Group’ which you are welcome to join, please indicated below if you would like to receive more details regarding our Patient Participation Group. This information will be posted out to you after your registration has been completed.**

**I do/do not wish to receive more information regarding the Patient Participation Group**

**As a new patient you will be given access to your electronic medical records. You will be given your pin number at your New Patient Health Check.**

**Confidentiality Statement**

**Every member of staff who works for the practice or another NHS organisation has a legal obligation to keep information about you confidential.**

**The practice Fair Processing Notice can be found on the practice website and in our patient leaflet.**

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**PLEASE TAKE THE TIME TO READ AND COMPLETE ALL FORMS ATTACHED TO THIS REGISTRATION PACK.**

**PLEASE ENSURE YOU HAVE COMPLETED A GMS1 FORM (ASK AT RECEPTION) FOR YOURSELF AND ALL OTHER MEMBERS OF THE FAMILY WHO ARE REGISTERING WITH THE PRACTICE.**

**THE DOCTOR YOU SEE TODAY WILL BECOME YOUR ALLOCATED NAMED GP, BUT YOU ARE WELCOME TO SEE ANY DOCTOR OF YOUR CHOICE WHEN ATTENDING.**

**THANK YOU FOR YOUR CO-OPERATION IN COMPLETING THIS FORM.**

|  |
| --- |
| **Practice use only;****Photo id – please state****Proof of address – please state****Signed** |