DR PALACIN SURGERY

NEW PATIENT QUESTIONNAIRE

Title……………Surname ……………………….Forename…………………… Date of Birth ………………………………………….

Address………………………………………………………………………………………………………………………………………………………

 Tele No: ………………………… Mobile No. ………………………Telephone No (relatives) …………………………………….

Occupation …………………… Marital Status: ………………Email address …………………………………………………………

Name & address of previous doctor …………………………………………………………………………………………………………

# **PERSONAL HEALTH INFORMATION**

Height ……………Weight …………… Have you ever smoked? Yes □ No □ Ex-smoker □

 If yes, how many a day …………………………..

 I would like to give up smoking □

**(If you would like help to give up smoking, our smoking advisor will contact you)**

How often do you have a drink that contains alcohol? (Please circle appropriate response)

Never □ Monthly or less □ 2-4 times/month □ 2-3times/week □ 4+ times/week □

**CARERS INFORMATION**

Are you a Carer for someone at home? ………… Relationship ………………………………………………………………………………

Are you a Carer for someone who does not live with you ………Relationship ………………………………………………………

Do you have a Carer? …………….. Name:…………………………………… Contact tele no. ……………………………………………..

**PERSONAL MEDICAL HISTORY** (Please list serious / chronic illness, operations, disabilities, accidents)

…………………………………………………………………………………………………………………………………………………………………………..

Are you currently receiving medical treatment from any hospital? Yes □ No □

(if so please give details and hospital name)…………………………………………………………………………………………………….

# **DRUGS AND MEDICINES:** Are you currently taking any medication, if so please give details-

…………………………………………………………………………………………………………………………………………………………………………..

…………………………………………………………………………………………………………………………………………………………………………..

…………………………………………………………………………………………………………………………………………………………………………..

…………………………………………………………………………………………………………………………………………………………………………..

Have you an allergy to any medication or anything else? Please list …………………………………………………………………

**FEMALE PERSONAL HEALTH**

Do you use contraception? Yes □ No □ If yes, please state which type: …………………………………………………..

Have you had any children? Yes □ No □ If yes, please list year of birth and sex: .......................................

……………………………………………………………………………………………………………………………………………………………………………

Have you had ahysterectomy? Yes □ No □ If yes, Date …………….Reason …………………….............................

Last cervical smear (date)………………………………Result ………………………………………………………………………………………..

**FAMILY MEDICAL HISTORY** (Parents/brothers/sisters)

Have any close family members suffered from any of the following

Asthma □ COPD □ Stroke □ Diabetes □ High Blood Pressure □ Epilepsy □

Cancer □ Sudden death □

**ETHNIC BACKGROUND**

May we enter your ethnic background onto your records? Yes □ No □

Please circle or underline your background:-

**White** - British/Irish/European/Other country ……………………………………………

**Mixed** - White & Black Caribbean/White & Black African,

 White & Asian/Any other mixed background

**Asian / Asian British -** Indian/Pakistani/Bangladeshi/Any other Asian background

**Black /** **Black British -** Caribbean/African/Any other Black background

**Chinese/Turkish/Other ethnic group –**

**CONSENT TO RECORD SHARING**

Do you consent to the sharing of data recorded in the surgery with any organisation that may care for you and the viewing of data by this Surgery that is recorded at other organisations, e.g. District Nursing, Community Podiatry Service, Chronic Conditions Service, Palliative Care, 111, Home Visiting Practitioner etc.

□ Consent given □ Consent refused

**SUMMARY CARE RECORD**

Your Summary Care Record contains your current allergies, sensitivities and medication and is used by Ambulance Services and A & E Departments to speed up any treatment you may need

Do you wish to share your Summary Care Record □ Yes □ No

**COMMUNITY PHARMACY**

Please indicate your preferred community pharmacy: - …………………………………………………………………………………

(This will be added to your record for prescriptions etc.)

**TEXT MESSAGING –** The surgery uses text messaging as a method of contact with our patients for appointment reminders, health promotion, influenza vaccination information etc.

Consent to SMS text messaging □ Yes □ No

Please speak to the receptionist if you require further information regarding this facility

**PATIENT PARTICIPATION GROUP** – We run meetings three times a year with tea and biscuits provided. We value patient feedback and would appreciate any ideas to put towards improvement of the Practice.

I would like to be involved in the Patient Participation Group information □

I would like to receive 2 yearly Practice Newsletters which provides important patient information □

**PROOF OF ADDRESS –** Please provide proof of address which can be your passport, driving licence or a household bill within the past 3 months.

I have included proof of my address □

This completed form should be returned to Reception with your other Registration forms. This information will be held in your personal health records, which like all NHS records remain confidential.

Patient name: …………………………………………………………………………. Date: ………………………………………..

Patient signature: ……………………………………………………………………

**Many thanks**

**ADMINISTRATION ONLY**

**Proof of Address:**

□Driving Licence □Passport □Household bill (dated within 3 months)

**Staff Member Registering**

…………………………………………………………………………………………

**Date of Registration**

…………………………………………………………………………………………...

**New Patient Check**

…………………………………………………………………………………………...

**FAO**

□ Smoking Cessation Advisor

□ PPG Secretary

□ Patient Newsletter