Chelston Hall Surgery
New Patient Health Questionnaire

Today's Date:

Please complete this confidential questionnaire (one for each member of the family to be registered with the Practice) and return to the surgery with identification.

Please complete in **BLOCK CAPITALS** and tick the boxes as appropriate.

If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.

Full name:				**Telephone number:**
Mr / Mrs / Miss / Ms / Other……..				
Address and postcode				**Mobile number:**
Next of kin and contact details				**Work Number**
Your E-mail address: *(IN CAPITALS PLEASE)*				**Occupation:**
Date of birth:		**Previous surnames**		**Are you a veteran?** **YES / NO**
Marital status:		**Gender:**		**Place of birth:**
School (child/student)				**NHS Number (If Known)**
Your previous address:				**Your main or 1st language spoken:**

Please tick if you require any of the following:

Interpreter ☐ Written information in large font ☐ Information in Braille ☐
Contact via carer ☐ Slow verbal communication ☐ Other (please provide details below) ☐

Other:

Previous Doctors name & address:	If **YOU** have **changed GP's** more than once within the **last year** please give the names of ANY other surgeries you have been registered with:

Please note: By supplying your mobile telephone number and email address, you are giving us permission to use them to send you appointment reminders, invitations and practice information. You can opt out of this by ticking the boxes below:

I DO NOT wish to be contacted via text ☐ **I DO NOT wish to be contact via email** ☐

Your ethnic origin: (tick one)	White (UK)	White (Irish)	White (Other)
Other black background	African	Asian	Chinese
Other mixed background	Caribbean	Other *(please state)*	Prefer not to say

Smoking, Alcohol Consumption and Exercise:				
Are you currently a smoker?	**Yes**	**No**	**Have you ever been a smoker? YES / NO**	**Year quit: Amount Per day:**
If so, how many cigarettes / cigars do you smoke per day? (for tobacco grams per week)			**How many units of alcohol do you drink in a week** *(One unit = 1 small glass of wine, a single measure of spirits, or 1/2 a pint of beer)*	

This is one unit of alcohol…


Half pint of "regular" beer, lager or cider


Half a small glass of wine


1 single measure of spirits


1 small glass of sherry


1 single measure of aperitifs

…and each of these is more than one unit

Pint of "regular" beer, lager or cider

Pint of "strong" or "premium" beer, lager or cider

Alcopop or a 275ml bottle of regular lager

440ml can of "regular" lager or cider

440ml can of "super strength" lager

250ml glass of wine (12%)

75cl Bottle of wine (12%)

Questions	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?	0 - 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.
If you have scored 5 or more please complete the additional Alcohol questions at the end of this form.

TOTAL SCORE:

Your Medical Background	
What significant illnesses have you had & when?	
What operations have you had and when?	
Please list any current medical problems	

Please list any tablets, medicines or other treatments you are currently taking: ***(including dose + frequency)***	***If possible please provide the list from your last repeat prescription***

Repeat Prescriptions

When you request your repeat medications we will send them directly to your chosen pharmacy electronically for you to collect from there.

Please provide the details of the pharmacy you wish to nominate for this:

Pharmacy Name: .....

Pharmacy Address: .....

Religion – Please advise us if you have any medical interventions you wish to decline or special requirements you may have due to religion:	**Height:**	**Weight:**

Are there any serious diseases that affect your Parents, Brothers or Sisters ***(please tick and state the family member affected)***	**Heart attack**	**Cancer**	**Angina**	**Epilepsy**
	Chronic lung disease	**High blood pressure**	**Asthma**	**Stroke**
	Diabetes	**Any other significant family illness?**		

Immunisations - Please tick all vaccinations that you have had and supply dates (where known)

Diptheria, Pertussis, Tetanus, Polio Hib		**Pneumococcal**	**Rotavirus**
1st -Age 2 months **2nd** - Age 3 months **3rd** - Age 4 Months		**1st** -Age 2 months **2nd** - Age 4 months **3rd** - Age 12 Months	**1st** -Age 2 months **2nd** - Age 4 months
Men C/Hib *Age 12 months*	**Men C** *Age 3 months*	**MMR - 1st –** 12 months **Booster** – 3 years	**Diptheria, Pertussis, Tetanus, Polio** *Booster given at 3 years*
Tetanus, Diptheria, Polio & Men C *Given at 14 years old*		**Seasonal Flu nasal Spray** (given to 2, 3 & 4 year olds)	**HPV** Given at 12-13 years old (girls only)

Any other vaccinations you have been given *(e.g. for international travel, please provide name and date)*

Specific Needs:
Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:

Please state any allergies and sensitivities you have:	
Please state any physical or mental disabilities you have:	

If you <u>are</u> an unpaid **Carer**, please state the name / address / phone number of the person you care for:	**<u>Person Cared For Contact Details:</u>**	
If the person you care for is registered at a different surgery please (with their permission) provide details of the surgery		
If you <u>have</u> an unpaid **Carer**, please state their name / address / phone number	**<u>Carer Contact Details:</u>**	
Please sign here if you are happy for us to disclose information about your health to your Carer.	**<u>Signed:</u>** **<u>Date:</u>**	
If your carer is registered at a different surgery please (with their permission) provide details of the surgery		
Is your carer happy for us to disclose to their own surgery that they are a carer	**Yes/No**	
Do you have a **"Living Will"** (a statement explaining what medical treatment you would not want in the future)?	**Yes / No**	***If "Yes", can you please bring a written copy of it with this form***
Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)?	**Yes / No**	**If "Yes", please state their name / address / phone number:**

For patients aged 65 and over or those with a chronic disease (e.g. asthma or diabetes)	
Have you had a flu vaccination? - Enter date or 'never'	
Have you had a pneumococcal vaccination? - Enter date or 'never'	

Women only:				
When was your last smear done?	Date	Was this at your GP's Surgery?	**Yes**	**NO**
What was the result of the smear?				
Date of last mammogram (if applicable):	Date	Method of contraception (if used):		

<u>Patient Participation Group</u>

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 experiences, views, and ideas for making services better.
By expressing your interest, you will be helping us to plan ways of involving patients that suit you.
It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice.
If you are interested in getting involved, please tick the box below and provide your email address

Yes, I am interested in becoming involved in the Practice Patient Participation Group (Please tick the "Yes" Box) Email:	Yes

National Data Opt Out

Your health records contain a type of data called confidential patient information. This data can be used to help with research and planning. The national data opt-out was introduced on 25 May 2018, enabling patients to opt out from the use of their data for research or planning purposes. You can view or change your national data opt-out choice at any time by using the online service at www.nhs.uk/your-nhs-data-matters or by calling 0300 3035678. Any choice you make will not impact on your individual care.

Information for new patients: about your Summary Care Record

If you are registered with a GP practice in England, you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

You may need to be treated by health and care professionals who do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex needs.

Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved make better and safer decisions about how best to treat you.

You have a choice

You have the choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care.

Your options are outlined below: please indicate your choice.

☐ **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies for adverse reactions only.

☐ **Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies for adverse reactions and further medical information that includes: your illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.

☐ **Express dissent for Summary Care Record (opt out).** Select this option if you **DO NOT** want any information shared with other healthcare professionals involved in your care.

If you choose not to complete this consent form, a Summary care Record (SCR) **will** be created for you, which will contain only medications, allergies and adverse reactions. You are free to change your decision at any time by informing your GP practice

Registration Health Check

As a newly registered patient you are welcome to make an appointment with our practice nurse for a new patient health check. This examination will include having your height, weight and blood pressure taken, and a specimen of urine for testing, help to establish relevant past medical and family history

If you take regular medication you will also need an appointment with a GP for a medication review – please bring along a list of medications from your previous surgery detailing your current medications.
We will arrange an appointment for this health check when you return this form to us.

Patient Signature:		**Signature on behalf of patient:**	
Proof of Identity and Address Provided?			
Birth Certificate	Driving Licence	Passport	Tenancy agreement
Utility Bill	Allowance Book	Solicitors letter	other

If you scored 5 or more in the alcohol questionnaire please complete the questionnaire below.

As alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest.

Questions	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	
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: ☐

FOR OFFICE USE ONLY										
Details of appt for new patient check:										
Details of appt with GP (med rev)										
Out of Area Registration					**YES / NO**					
University Student returning as OOA					**YES /NO**					
University student returning permanently					**YES / NO**					
Check list for staff:	**PLACE OF BIRTH**		**Previous Address**		**Previous GP**		**SUMMARY CARE RECORD**		**PURPLE FORM SIGNED**	