Addingham Centre Logo FIN.tif

**NEW PATIENT QUESTIONNAIRE**

**Further Information about the Practice is available at www.addinghamsurgery.nhs.uk**

It may be sometime before we receive your medical records. This questionnaire will give the doctors important information about your history and will help us to give you a better service. Please complete as fully as possible.

**PATIENT DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| **Title:** | Mr □ Mrs □ Miss □ Ms □  Dr □ Other: | **Surname:** |  |
| **Date of Birth:** |  | **First Name:** |  |
| **Occupation:** |  | **Marital Status** | Single □  Married □  Divorced □ Widowed □  Civil Partnership □ |
| **Home Address:**  **Postcode:** | | **Home Tel:** |  |
| **Work Tel:** |  |
| **Mobile:**  We will send you appointment reminders and health information direct to your mobile phone, if you do not want this service, please tick here □ |  |
| **Email:** |  |
| **Next of Kin (name):** | | **Relationship:** | |
| **Next of Kin Address and Telephone Number in case of an emergency:** | | | |

**Language Spoken**

|  |  |
| --- | --- |
| What is you first language? | Do you speak English? □ Yes □ No |
| Do you require an interpreter? □ Yes □ No | |

**PROOF OF ID AND ADDRESS WILL BE REQUIRED**

|  |  |  |  |
| --- | --- | --- | --- |
| □ Birth Certificate  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Staff only: Date & Place | □ Photo Driving Licence  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Staff only: Licence number | □ Bank or Mortgage Statement  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Staff only: Institution & date | □ Passport  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Staff only: Number |
| □ Allowance Book | □ Offer of Tenancy | □ Solicitors Letter | □ Other |

**MEDICAL INFORMATION**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Have you or any close family (Parents/Siblings) suffered from? (tick as appropriate) | | | | | |
| **Condition** | **You** | **Close Relative** | **Condition** | **You** | **Close Relative** |
| Epilepsy |  |  | Blindness(Glaucoma) |  |  |
| High Blood Pressure |  |  | Diabetes |  |  |
| Heart Attack/Stroke |  |  | Depression |  |  |
| Cancer |  |  | Asthma |  |  |
| Eczema/Hay Fever |  |  | COPD |  |  |
| Any other Chronic Illness or Medical Problem we should know about? | | | | | |
| Are you currently pregnant? □ Yes □ No | | | | | |
| **MEDICATION** | | | | | |
| **Do you take regular medication?** □ Yes □ No  If so, please bring in your tear off slip from your last prescription from your previous GP, this will give us the information we need when processing your medication.  Please make sure you have a month’s supply of medication before registering with us. | | | | | |
| Are you allergic to anything? Please provide details. | | |  | | |

**ELECTRONIC PRESCRIPTIONS**

|  |  |
| --- | --- |
| Who would you like your nominated pharmacy to be? (Please give address) |  |

**DISABILITIES AND OTHER NEEDS**

Do you consider yourself to be disabled? If yes, what type of disability do you have?

It is important for us to identify and log a patient’s requirements in their medical notes if they have a recorded disability.

|  |  |
| --- | --- |
| Registered Blind □ Yes □ No | Visual Impairment □ Yes □ No |
| Registered Partially Sighted □ Yes □ No | Hearing Difficulties □ Yes □ No |
| Registered Deaf □ Yes □ No | Use of Hearing Aids □ Yes □ No |
| Registered Deaf/Blind □ Yes □ No | Other: |
| Learning Disability □ Yes □ No |
| Do you have any communication/information needs relating to a disability or sensory loss and if so what they are? For example, letters printed in size 28+ font. | |
|  | |

**OTHER INFORMATION**

|  |  |
| --- | --- |
| **Smoking** | |
| Do you smoke? (Please circle) | Never Ex-Smoker Vaper Current Smoker |
| If you are a current smoker, how many do you smoke a day? |  |
| **Alcohol** | |
| Do you drink alcohol? | □ Yes □ No |
| If yes how many units per week? |  |
| **Allergies** | |
| Are you allergic to anything? | □ Yes □ No |
| If yes, please give details: |  |
| **Carers** | |
| Do you have a carer? | □ Yes □ No |
| If yes, please give details: | |
| Are you a carer? | □ Yes □ No |
| If yes, please give details: |  |

**Consent to Share Records**

Addingham Medical Centre uses a computer system called SystmOne that allows the sharing of full electronic records across different NHS healthcare services. Clinicians at other organisations that care for you (e.g. out of hours and physiotherapy) and use SystmOne will be able to see the information recorded here. For example, a district nurse that visits you would be able to see the data entered by your GP.

Please tick this box if you are not happy for your records to be shared. □

Thank you for taking the time to complete this medical questionnaire, the information you have supplied will help improve our service to you.

**THE INFORMATION GIVEN IS IN STRICTEST CONFIDENCE AND ONLY USED BY YOUR HEALTH PROFESSIONAL**

|  |  |
| --- | --- |
| **Signature of Patient** | **Date** |
|  |  |