**New Patient Questionnaire - Adult**

*Welcome to Neetside Surgery. Please take a few moments to fill out this questionnaire. The information we collect is* ***strictly confidential*** *and is used to ensure that we can provide the best care for you. It would help us greatly if you could fill in both sides and all questions are answered. Thank you. The Neetside Surgery Doctors*

***Please provide proof of ID when returning the completed forms e.g birth certificate***

**Personal Details**

Name……………………………………… DOB……................... Home Tel No. ………… Mobile NO. ……………

Next of Kin……………………… Relationship to patient……………................ Next of kin contact no. …………….

Gender (please let us know if different from birth)……………………….Ethnic Origin…………… Height…………Weight……………… Occupation / Place of education ……………………………

**Please chose your preferred Chemist**

Prescriptions: My preferred chemist for prescriptions to be sent to is ………………….…………………...

(Bude Pharmacy, Boots, Belle Vue Chemist or Stratton Pharmacy)

All above chemists use electronic prescribing (EPS) please tick the box if you are happy to use this service 🞎

**Summary Care Record**

**This gives your consent for authorised NHS staff to see your medication and allergies (and in the future your basic medical history)**

**YOU MUST SELECT ONE FROM THE LIST BELOW**

Express consent for medication, allergies and adverse reactions only 🞎

\*Express consent for medication, allergies, adverse reactions AND additional information 🞎\* (recommended)

Express dissent (Opt out) 🞎

**LIVI DOCTORS – available by downloading the LIVI APP (Over 2’s only)**

This gives you access to an NHS GP for medical advice, prescriptions and referrals.

In order for Livi to access your records, you will need to give express consent for record sharing (above)

**Carers/Carees**

Are you a carer for a relative, friend or neighbour? Y 🞎 N🞎 If yes, who do you care for?……………………………

Are you being cared for by a relative, friend of neighbour? Y 🞎 N🞎 If yes, Name of carer?…………………………

Do you or your carer have any information or communication needs relating to a disability, impairment or sensory loss? Y 🞎 N🞎 If yes, do you have any special requirements? (Larger writing, brail etc)

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

**Specific Needs:** Please detail any specific needs you have so the Practice can ensure they are identified and accommodated:

Please state any sensory impairment you may have: Speech🞎 Hearing 🞎 Sight 🞎

Are you an ‘Assistance Dog’ user? Yes 🞎 No 🞎

Please state any Physical Disabilities you have: ……………………………………………………..……….……..

Please state any Mental Disabilities you have: ……………………………………………………….…….……….

Please state any requirements you have to be able to access the Practice Premises:………………….……………..

Please state any Religious or Cultural needs: ……………………………………………………….….……………
Do you require the help of a Translator/Interpreter: ……………………………………………….………………...

**Medical History** (Please record any current or previous major illness, health problems or operations)

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

**Referrals**

Are there any investigations/referrals outstanding from your previous GP? Yes 🞎 No 🞎
If yes please provide additional information …………………………………………………………………………….

**Medication** Current medication (If possible please provide a previous repeat prescription slip -we can take a copy)

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

**Allergies**……………………………………………………………………………

**Family History**

Is there a close **family history** of any of the following illnesses?

Stroke………… High blood pressure……........ Heart Disease…………… Diabetes………………………
Other (please specify) …………………………… None / unknown 🞎

**Exercise**
What do you do for exercise and how often?

…………………………………………………………………………………………………………………………… **Smoking:** Are you a smoker? Current 🞎 Ex Smoker 🞎 or Never Smoked 🞎

**Current Smoker**……………cigs/day Would you like help to stop? YES🞎 NO 🞎

**Ex Smoker**………..cigs/day When did you stop?............................

**Females only:**

What form of contraception do you currently use? ……………………………………………………………..

**Veterans / armed forces only:**

Dates of service ………………..

Date of discharge ………………

Address prior to serving in the armed forces ……………………………………………………………………

Which force did you serve in? …………………………………………………………………………………..

 **Outside the UK: (Please provide a copy of your medical records from abroad where applicable)**

Is this your first time registering in the UK? Yes 🞎 No 🞎
If YES, what date did you arrive in the UK? ……………………

If No, please provide your previous address in the UK and the dates you where out of the UK……………….

 **CONSENT FORM TO RECEIVE TEXT AND EMAILS FROM**

**NEETSIDE SURGERY**

**Full Name:** …...………………………………………………..….  **Date of birth:** ………………..……….

**Mobile no:** …………………………………..………….………… **Landline** ………………………………

**Email address:** …………………………..…………………………………….……………………………….

I give my consent to receive text message reminders from the surgery YES ⎕ NO ⎕

I give my consent to receive emails from the surgery YES ⎕ NO ⎕

Preferred method of written contact: Letter ⎕ Email ⎕ Text Message ⎕

Signed ……………………………………………............................ Dated ………………………………..

(Please hand in at reception when completed)

**AUDIT – C**

|  |  |  |
| --- | --- | --- |
| **Questions** | **Scoring system** | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink containing alcohol? | Never | Monthlyor 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 |  |

 **TOTAL**

**(1 unit = 1 small glass of wine, half a pint of ordinary strength beer or a single measure of spirits)**

**Scoring:**

**If you score 5 or over please complete second part below**

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

**ONLINE ACCESS TO HEALTH RECORDS REQUEST**

**Section 1: Patient details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Surname** |  | **Former name** |  |
| **Forename** |  | **Title** |  |
| **Date of birth** |  | **Address:** |  |
| **Telephone number** |  | **Postcode:** |  |
| **NHS number (if known)** |  | **Hospital number (if known)** |  |

**Section 2: Record requested**

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

|  |  |
| --- | --- |
| Requesting repeat prescriptions | 🞏 |
| Access to my medical records | 🞏 |

I wish to access my medical record online and both understand and agree with each of the following statements (tick):

|  |  |
| --- | --- |
| I have read and understood the information leaflet provided by the organisation | 🞏 |
| I will be responsible for the security of the information that I see or download | 🞏 |
| If I chose to share my information with anyone else, this is at my own risk | 🞏 |
| I will contact the organisation 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 is not about me or is inaccurate, I will contact the organisation as soon as possible | 🞏 |

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient signature** |  | **Date** |  |

 **Proof of identity:**

Under the Data Protection Act 2018, you do not have to give a reason for applying for access to your own health records. However, all applicants will be asked to provide two forms of identification, one of which must be photographic identification before access can be set up.

Please speak to reception if you are unable to provide this.

ADDITIONAL NOTES:

Before returning this form, please ensure that you have:

• Signed and dated the form

• Read and understood the welcome letter and appointment system

• Are able to provide proof of your identity or alternatively confirmed your identity by a countersignature

• Enclosed documentation to support your request (if applicable)

**Incomplete applications will be returned; therefore, please ensure you have the correct documentation before returning the form.**