NEW PATIENT QUESTIONNAIRE FORM

Please note that any information supplied will not affect your registration at this surgery, it is important to know so that we can ensure correct information is stored on your medical record. Your registration will be complete once you have had your New Patient Health Check. Please book this ASAP with Reception if you have not done so already.

Mr/Mrs/Ms/Miss Forename**:** _ _ _ _ _ _ _ _ _ Surname**:** _
Date of Birth**:** _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Home Tel**:** _
Mobile Tel**:** _

By giving us your mobile number you are accepting SMS messages from Queensway Surgery

Email Address: _

Queensway surgery offers safe and secure Online Access to the following services by default to all newly registered patients:

- Booking and cancelling appointments
- Viewing and Ordering Repeat Medication

By supplying your email address, we assume you would like an online account to be able to access these services from home – if you would **not** like to have an online account please tick this box ☐

Local Chemist/Pharmacy name: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Queensway surgery will send any prescriptions for you directly to the pharmacy/chemist you name above.

Ethnicity (please circle)

White British British/Mixed British White Irish Irish Other White

White/Black Caribbean White/Black African White/Black Asian Other Black Other Mixed

Indian/British Indian Pakistani/British Pakistani Bangladeshi/British Bangladeshi Other Asian

Main Language spoken: _ _ _ _ _ _ _ _ _ _ _ _ **Do you speak English?** (Please circle) YES/NO

Allergies:

Current Medication _
_ _
_ _
_ _
_ _

Please continue on reverse if required. Please include any non-prescription and over the counter that you regularly use.

Do you smoke? YES/NO (if yes, see below) I have never smoked tobacco

If yes how many each day? ……………. I have not smoked since ……………………..

We offer an excellent stop smoking service - If you would like our help please contact reception.

Alcohol intake (please complete table below)

Questions		Scoring System				Your Score
	0	1	2	3	4	
How often do you have a drink that contains alcohol?	Never	Monthly or less	2 – 4 times Per month	2 - 3 times per week	4+ times per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1 – 2	3 - 4	5 - 6	7 - 9	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Family History (please circle all that apply)

High Blood Pressure Diabetes Cancer Heart Disease Stroke

YOUR PERSONAL MEDICAL HISTORY

Listed below are some diseases/conditions. You will see each has a "current" box, and some also have a "past" box. Please tick any boxes that apply to you e.g., if you had Asthma as a child but don't have Asthma anymore, then you would tick the "past" box; another example, if you have cataracts and are having or waiting for treatment, then you would tick the "current" box.

Disease/Condition	Current (Onset date if known)	Past
Angina		
Heart Attack		
Coronary Heart Disease		
Heart Failure		
Stroke/TIA		
Hypertension		
Pacemaker		
Atrial fibrillation		
Peripheral arterial disease		
Asthma		
COPD		
Diabetes Type 1		
Diabetes Type 2		
Epilepsy		
Cancer (please could you give details)		
Have you been formally diagnosed with a Mental Health condition– please specify		
Depression		
Dementia		
Chronic Kidney Disease(CKD) Stage 1 / 2 / 3 or 4		
Learning Difficulties e.g. ADHD, Dyslexia		
Autism / Asperger's		
Have you been formally diagnosed with a Learning Disability: mild/moderate/severe		

Osteoporosis (have you had a bone density scan in the last 3 years?)		
Arthritis		
Fibromyalgia		
Chronic Fatigue (ME)		
Multiple Sclerosis		
Eye disease – please specify		
Gastrointestinal disease		
Coeliac Disease		
Sexually Transmitted Disease (please specify eg Chlamydia)		
Hyperthyroid/overactive thyroid		
Hypothyroid/underactive thyroid		
Other – please specify		

Are you a carer for a relative, friend or neighbour? (Please circle) **YES/NO**

Is there a relative, friend or neighbour who helps to look after you? (Please circle) **YES/NO**

Please give details **Name:**_____________________ **Contact No:** _____________________

Next of Kin (Mr / Mrs / Ms / Miss) (please circle)_ _

Tel: _

Relationship to patient _

Details of any family members registered at the Practice (e.g. mum/dad/brother/sister)

Name: _ **Date of Birth:** _ _ _ _ _ _ _ _ _ _ _

Address _
_ _

Telephone Number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Details of any family members registered at the Practice (e.g. mum/dad/brother/sister)

Name: _ **Date of Birth:** _ _ _ _ _ _ _ _ _ _ _

Address _
_ _

Telephone Number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

INFORMATION FOR NEW PATIENTS: ABOUT YOUR SUMMARY CARE RECORD

Dear patient,

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.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. 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 care 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 in your care 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 on the form overleaf.

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 chose not to complete this consent form, a core Summary Care Record (SCR) **will** be created for you, which will contain only medications, allergies and adverse reactions.

Once you have completed the consent form, please return it to your GP practice.

You are free to change your decision at any time by informing your GP practice.

Summary Care Record patient consent form

Having read the above information regarding your choices, please choose **one** of the options below and return the completed form to your GP practice:

Yes – I would like a Summary Care Record
□ Express consent for medication, allergies and adverse reactions only.

or

□ Express consent for medication, allergies, adverse reactions and additional information.

No – I would not like a Summary Care Record
□ Express dissent for Summary Care Record (opt out).

Name of patient: ……

Date of birth: …… Patient's postcode: ……

Surgery name: …… Surgery location (Town): ……

NHS number (if known): ……

Signature: ……. Date: ……

If you are filling out this form on behalf of another person, please ensure that you fill out their details above; you sign the form above and provide your details below:

Name: ……

Please circle one: Parent

Legal Guardian

Lasting power of Attorney for Health & Welfare