PARK PARADE SURGERY

NEW PATIENT QUESTIONNAIRE

ID Verified for online services:
1)
2)
Staff Initials:

PERSONAL INFORMATION:

Title:…… First Name(s):……..

Surname:…… Date of Birth:…….....

Contact details:

Mobile:…… Home phone:……

E-mail address: ……

(By giving us this information you are happy for us to email information to you relating to your care)

Do you consent to us sending you text messages relating to your care e.g. appointment reminders and when we need you to contact the surgery? **Yes / No**

Do you consent to us leaving messages on your answer phone? **Yes / No**

Do you consent to us informing another member of the household that the surgery has phoned? **Yes / No**

What is your preferred method of contact? (Please circle) **Email** **Text** **Letter**

Next Of Kin details: Name:……..

Contact Number …… Relationship:…….....

PRESCRIPTIONS: – to be ordered online

Prescriptions are sent electronically to your nominated pharmacy

Please tell us which pharmacy you would like to use:……

CARER STATUS:

Please let us know if you are the main person responsible for looking after and caring for someone who is dependent upon you:

Are you a Carer? **Y / N**

Do you have a Carer? If **Yes** please could you provide us with their details: **Y / N**

Name:……

Carer contact details:……..

CHILDREN UNDER 12

Do you wish to nominate another person who has your permission to give consent for urgent medical treatment in an emergency? E.g. childminder, grandparent or other relative etc.

Name:……

Contact Number …… Relationship:…….....

Does your child have a social worker? **Yes / No**

If **Yes** please could you provide us with their details:

Name …… Contact Number:…….....

ETHNIC ORIGIN: (please tick one box)

In accordance with new Public Health requirements we require the following information.

Please state your first language:……

Please indicate your ethnic origin by ticking one option from the list below

British/Mixed British		Irish		Other White Background	
White & Black Caribbean		White & Black African		White & Asian	
Other Mixed Background		Indian or British Indian		Pakistani or British Pakistani	
Bangladeshi or British Bangladeshi		Other Asian Background		Caribbean	
African		Other Black Background		Chinese	

Ethnic category not stated, please specify ……..

COMMUNICATION NEEDS:

Do you have any specific information or communication needs? If so, please specify how we can meet these for you (e.g. large print, Braille, easy read communications)

……..
……..……...

If you do have any specific information or communication needs, please confirm if you consent to us sharing these with other NHS or social care professionals who provide care for you, by ticking the appropriate box below:

Yes I consent ☐ **No I do not consent** ☐

YOUR HEALTH

SMOKING INFORMATION:

Do you smoke? **Yes / No** If **Yes** how many per day?.....

Have you ever smoked? **Yes / No** If **Yes** when did you stop?.....

ALCOHOL INTAKE INFORMATION:

Please help us by answering the three questions below.

If you score 5 or more then please answer the additional questions below.

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	

Scoring:

Please calculate your total score:……

If your score is less than 5 then there are no more alcohol related questions. Please go to 'Your Health Continued' Section on Page 5

A total of 5 or more indicates increasing or higher risk drinking.

If your score is 5 or more then please complete the additional questions.

Remaining questions (only complete if scored 5 or more)

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	

Questions	Scoring system					Your score
	0	1	2	3	4	
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	

Please calculate your total score:……..

Scoring:

0 – 7 Lower risk
8 – 15 Increasing risk
16–19 Higher risk
20+ Possible dependence

YOUR HEALTH continued

We will receive your full medical notes from your previous GP practice but in the meantime is there anything you would like us to know about your recent health?

Do you need regular GP reviews? **Yes / No**

If **Yes** please could you please give brief details:

.....

Are you currently under the care of any hospital consultants or are waiting to be referred? **Yes / No**

If **Yes** please could you give the hospital department and any other brief details:

.....

.....

Are you aware of any pending follow-up tests? **Yes / No**

Is there anything in your recent medical history that you feel should be monitored / followed up? **Yes / No**

.....

Are you taking any repeat medications? **Yes / No**

If **Yes** please could you attach your repeat prescription 'tick list' from your previous surgery, if you have one.

Have you ever had any of the following?

Condition		**Details**
Allergies	**Yes / No**	
Heart disease including Angina	**Yes / No**	
Stroke	**Yes / No**	
Diabetes Type 1 or Type 2	**Yes / No**	
Asthma /COPD or Respiratory Disease	**Yes / No**	
Hypertension	**Yes / No**	
Infectious Disease (HIV, HEP B, HEP C, HEP D, MRSA, C Difficile, TB)	**Yes / No**	
Liver / Kidney Disease	**Yes / No**	
Thyroid Disease	**Yes / No**	
Cancer	**Yes / No**	
Are you currently pregnant	**Yes / No**	
Neurological Conditions e.g. Epilepsy / MS	**Yes / No**	

ONLINE SERVICES

For anyone aged 16 and over we offer online services for appointment booking and repeat prescription ordering. **This is the quickest & easiest way to order your medication.**

We will need to see 2 forms of ID to be able to register you for online services, preferably 1 photo and 1 with proof of your current address (within 3 months).

Once registered, you will also be able to view your summary record, detailing current medication, allergies and vaccinations

Would you like to register for our online services? **Yes / No**

(If you decide not to use online services you will need to bring your prescription request into the surgery as we are unable to accept either telephone or pharmacy requests)

How would you like us to provide your username and password? (Please circle)

Email Text Letter

These are confidential: It is your responsibility to ensure they can be received securely by text or email. Please note that photographic ID will be needed if collecting a printout.

You will also be provided with details for registering with the approved 'Systmonline App' if you wish to use it.

For children under 11 years:

An adult with parental responsibility can nominate themselves to have access to their child's online services. Once a child reaches 11, access is automatically removed. Please provide details below of the adult requiring access:

Name:……

Contact Number …… Relationship:…….....

NHS number:…… Date of Birth:……

Address:……

Proxy access:

If you are aged 16 or over you can nominate another person (called a 'proxy') to have access to your online Services (this is called proxy access). This will allow the nominated person to access your on-line account to book appointments and order prescriptions. You can choose to end this access at any time after it has been granted. ID checks would need to be done on the nominated proxy.

If you would like to nominate a person to have proxy access, please ask at reception for an application form.

Access to your medical records:

If you would like online access to your medical record you can apply for this by requesting an application form from reception or by downloading one from the practice website. This access is subject to an authorisation process and can take up to 20 working days to complete once your application has been received. You will need to provide 2 forms of ID (including 1 photographic) on application, which needs to be done in person.

For further information on GP online services go to: **www.nhs.uk/GPonlineservices**

YOUR MEDICAL INFORMATION – SHARING YOUR DATA:

Under the General Data Protection Regulations (GDPR), we have a responsibility to keep your medical records confidential. We need your consent to share this with other authorised health professionals involved in your care or in planning your care. More information is available on the website or the number below.

Please see the Privacy Notice on our website for more information on how your data is held and used by the practice. www.parkparadesurgery.nhs.uk

Enhanced Data Sharing: (www.parkparadesurgery.nhs.uk) We would like to make your whole medical record **AVAILABLE** to other **authorised healthcare staff**, involved in your care (eg the District Nurse). They will not see your record unless you **GIVE** them your permission to see it. **Do you consent to this?**	**Yes**	**No**
Enhanced Data Sharing: Park Parade Surgery would like to see your whole medical record, including information created by other **authorised healthcare staff** involved in your care. **Do you consent to this?**	**Yes**	**No**
Summary Care Record: (www.nhscarerecords.nhs.uk) This record will contain summary information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had to ensure those caring for you have enough information to treat you safely. Your Summary Care Record will be available to **authorised healthcare staff** providing you with care anywhere in England, but they will ask your permission before they look at it. This means that if you have an accident or become ill away from home, healthcare staff treating you will have immediate access to important information about your health. **Do you consent to having a Summary Care Record?**	**Yes**	**No**
Your Data Matters: (www.nhs.uk/your-nhs-data-matters Tel: 0300 303 5678) **The NHS wants to make sure you and your family has the best care now and in the future. Your health and adult social care information supports your individual care. It also helps us to research, plan and improve health and care services in England.** **There are very strict rules on how this data can and cannot be used, and you have clear data rights. We are committed to keeping patient information safe and will always be clear on how it is used.** **You can choose whether or not your confidential patient information is used for research and planning.** **If you do not wish your information to be used in this way please opt-out by visiting the website www.nhs.uk/your-nhs-data-matters or calling 0300 303 5678. The practice is unable to record this for you.**		

YOUR SIGNATURE:…… DATE……...