

New Patient Questionnaire

Please fill in the following questionnaire. It is designed to give us essential details about your medical background, so we can give you the best service whilst under our care. All information given on this form will be kept confidential.

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| **1- General Information About You** | | | | | |
| Title |  | | Family Name: | |  |
| First Name: |  | | Middle Name(s) | |  |
| Date of Birth:  (DD/MM/YYYY) |  | | NHS Number:  (if known) | |  |
| Gender: |  | | Marital Status: | |  |
| Home number: |  | | Work number: | |  |
| Mobile number: |  | |  | |  |
|  | | | | | |
| Email address: | |  | | | |
| Would you like to **opt out** of receiving text messages from the Practice? These may include appointment reminders and service notifications but will not include any marketing messages. | | | Yes / No\* | \*By choosing NO you are agreeing to receive mobile text messaging from Elvington Medical Practice. | |
| **Patient Representation Group**  This group represents our patients to help us develop and improve our services, and meets quarterly.  ****Yes I would like to take part.  ****No I would not like to be part. | | | | | |
| Main spoken Language: |  | | | | |

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| **2-Carers** A carer is an unpaid individual who looks after a relative, friend or neighbour who needs help due to illness, disability, addiction or in need of emotional support. | | | |
| **Do you look after someone?** | Yes / No | **If YES, who?** |  |
| **Does someone look after you?** | Yes / No | **If YES, who?** |  |

*Please turnover…*

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| **3- Smoking** | | | |
| **Have you ever smoked?** |  | **Current cigarettes smoked per day:** |  |
| **If YES, do you smoke now?** |  | **Current cigar/pipes**  **per day:** |  |
| **If you are an ex-smoker, when did you stop?** | |  | |

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| **4- Family History** | | | | |
|  | **Age** | **State of Health/Cause of Death** | **Age at Death** | **Living at same address** |
| **Father** |  |  |  |  |
| **Mother** |  |  |  |  |
| **Spouse** |  |  |  |  |
| **Brothers/Sisters** |  |  |  |  |
| **Children** |  |  |  |  |

**Alcohol Screening Questionnaire**

**The Government has asked practices to collect information relating to the amount of alcohol patients drink. Practices use this information to identify patients who might benefit from some additional intervention and support. If you do not want to answer these questions please write DECLINED.**

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| **5-Alcohol** | | | | | | | |
|  | **0 Points** | **1 Point** | **2 Points** | | **3 Points** | | **4 Points** |
| **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 |
| ***There is no need to proceed with the remaining screening questions if you answered “Never” to this first question.*** | | | | | | | |
| **How many standard alcoholic drinks do you have on a typical day when you are drinking?** | 1-2 | 3-4 | 5-6 | 7-8 | | 10+ | |
| **How often do you have 6 or more standard drinks on one occasion?** | Never | Less than monthly | Monthly | Weekly | | Daily or almost daily | |

**If you scored 5 or more on the above questions, please complete the additional questionnaire on the next page. Thank you.**

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| **5- Alcohol** | | | | | | |
| **Questions** | **Scoring Systems** | | | | | **Score** |
|  | 0 | 1 | 2 | 3 | 4 |  |
| How often in the last year have you found were not able to stop drinking once you had started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often in the last year have you failed to do what was expected of you because of drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often in the last year have you needed an alcoholic drink in the morning to get you going? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often in the last year have you had a feeling of guilt or regret after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often in the last year have you not been able to remember what happened when drinking the night before? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| Have you or someone else been injured as a result of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| Has a relative/friend/ doctor/health worker been concerned about your drinking or advised you to cut down? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |

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| **6- Health History** | |
| **Date:** | **Illnesses, accidents or operations:** |
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| **7- Known allergies to medication or other** | |
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| **8- Questions for female patients only** | | | |
| **Have you ever had a cervical smear?** | Yes / No | **If YES, where?** | *GP / FPC / Hospital / Other* |
| **When was your last smear?** |  | **Smear result:** | *Normal/ Early recall /Colposcopy* |
| **Have you ever had breast screening?** | Yes / No |

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| **Thank you for completing this questionnaire** | | | |
| **Signed:** |  | **Date:** |  |

**PATIENTS UNDER THE AGE OF 18**

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| --- |
| **Home educated Y/N** |
| **Name and address of school attended** |

**Online Access**

**All requests are subject to approval by a GP, to ensure it is safe for you to have access to your online medical record.**

**If you would like access to your online medical record please tick**

**If yes, please verify your email address**

**You will receive access via email notification unless you here otherwise.**

**Please sign and date to state you understand this request will be reviewed by a GP before access is granted.**

**Signed…………………………………………………**

**Date………………….**

**Patient Ethnic Origin Questionnaire**

*This questionnaire follows the recommendations of the Equality and Human Rights Commission and complies with the Equality Act 2010.*

**Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with early identification of some of these conditions.**

**Choose ONE section from A to E, then tick ONE box to indicate your background.**

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| --- | --- | --- | --- |
| **NAME:** |  | **DATE OF BIRTH:** |  |

**A. WHITE**

|  |  |
| --- | --- |
|  | **British** |
|  | **Irish** |
|  | **Any other white background please state below** |

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**B. MIXED**

|  |  |
| --- | --- |
|  | **White and Black Caribbean** |
|  | **White and Black African** |
|  | **White and Asian** |
|  | **Any other mixed background please write below** |

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**C. ASIAN OR ASIAN BRITISH**

|  |  |
| --- | --- |
|  | **Indian** |
|  | **Pakistani** |
|  | **Bangladeshi** |
|  | **Any other Asian background please write below** |

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**D. BLACK OR BLACK BRITISH**

|  |  |
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|  | **Caribbean** |
|  | **African** |
|  | **White and Asian** |
|  | **Any other black background please write below** |

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**E. CHINESE OR OTHER ETHNIC GROUP**

|  |  |
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|  | **Chinese** |
|  | **Any other please write below** |

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