

New Patient Questionnaire

Please complete in BLOCK CAPITALS and tick boxes as appropriate. Please make sure you have photo ID and proof of address with you when registering. If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.

Please complete a separate form for each family member to be registered.

Full name:	Date of Birth: / /
Address:	Signature:
Telephone number:	Acceptable method of contact; Yes <input type="checkbox"/> No <input type="checkbox"/>
Mobile number:	Yes <input type="checkbox"/> No <input type="checkbox"/> Text / SMS: Yes <input type="checkbox"/> No <input type="checkbox"/>
Work number:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Email:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Next of Kin:	Relationship:
Address:	Contact telephone number:
Employment status: Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Self Employed <input type="checkbox"/> Retired <input type="checkbox"/> Other <input type="checkbox"/>	
What is your ethnic group? White British <input type="checkbox"/> Other White background <input type="checkbox"/> White and Black Caribbean <input type="checkbox"/> White and Black African <input type="checkbox"/> Indian or British Indian <input type="checkbox"/> Chinese <input type="checkbox"/> White and Asian <input type="checkbox"/> Pakistani or British Pakistani <input type="checkbox"/> Other Asian Background <input type="checkbox"/> Bangladeshi or British Bangladeshi <input type="checkbox"/> Ethnicity unknown <input type="checkbox"/> Ethnic category not stated <input type="checkbox"/>	
Height:	Weight:
Blood Pressure:	

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Smoking status:

Current smoker Yes No If Yes, how many per day?.....

Ex-Smoker Yes Non-Smoker

Please see reception for information on stop smoking support services.

Do you suffer from any of the following:

Diabetes High Cholesterol Any Heart Problems

Epilepsy High Blood Pressure Chronic Kidney Disease

Under Active Thyroid Asthma / Respiratory Disease

If any of the above is ticked in this section please give a few details.

Do you Have any Allergies?

Please give details of any current medication you are taking.

Who is your usual pharmacy, name & address?

Electronic delivery of Prescriptions to your pharmacy? Yes No

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What is the name & address of your previous doctor's surgery?

What is the reason for registering at the Providence Surgery?

Are you a Carer? Yes No

If yes, please could you provide further details below for who you care.

Name: Address:

Information is available for support services, contact reception.

Patient Participation Group

The Practice is committed to improving the services we provide to our patients. To do this, it is important that we hear from patients about their experiences, views and ideas for making services better. The patient participation group gives you the opportunity to do this. If you are interested in getting involved please tick the box and we will contact you.

Summary Care Record – your emergency care summary

The NHS in England is introducing the Summary Care Record, which will be used in emergency care. The record will contain 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 your 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, the doctors treating you will have immediate access to important information about your health.

Your GP practice is supporting Summary Care Records and as a patient you have a choice:

Yes I would like a Summary Care Record – you do not need to do anything and a Summary Care Record will be created for you.

No I do not want a Summary Care Record – Please ask reception for a form.

SystemOnline is our web portal for registered patients (age 18 and over only), here you can;

Book Appointments

Order Repeat Prescriptions

View your Medical records

Manage their Hospital referral documentation

Please register me for SystemOnline: Yes No






Photo ID is required unless returning this form in person to a doctor

New Patient Questionnaire

Name:

DOB:

FAST scoring key

One drink =  Half pint of regular beer, lager or cider  1 small glass of wine  1 single measure of spirits  1 small glass of sherry  1 single measure of aperitifs

For the following questions please circle the answer which best applies:

MEN: How often do you have 8 or more drinks on one occasion? Women: How often do you have 6 or more drinks on one occasion?				
0 Never	1 Less than monthly	2 Monthly	3 Weekly	4 Daily or almost daily

How often during the last year have you been unable to remember what happened the night before because you have been drinking?				
0 Never	1 Less than monthly	2 Monthly	3 Weekly	4 Daily or almost daily

How often during the last year have you failed to do what was normally expected of you because of drinking?				
0 Never	1 Less than monthly	2 Monthly	3 Weekly	4 Daily or almost daily

In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?		
0 Never	2 Yes, on one occasion	4 Yes, on more than one occasion