Confidential New Patient Questionnaire

Please complete this confidential questionnaire which will help our clinicians appreciate your healthcare needs

Personal details – please complete in BLOCK capitals					
Title	Mr/Mrs/Miss/Ms/Other	Other, Please Specify			
Surname		Forename			
Previous Surname/s		Date of birth			
Preferred Name		Have you been registered here before?	Yes/No		
Home Tel no		Mobile No.			
E mail		Occupation			
Please provide details for someone we can contact in the event of an emergency					
Full Name		Contact No.			
Address					
Relationship to you		Is the person a patient of this practice?	Yes/No	Gender	M / F
Spoken language of your emergency contact					
Will they need an interpreter?					
Is this person also your next of kin?	Y/N				

SMS Messaging - Would you like to receive text messages?	*Yes / No	***If yes – please sign the consent box below.**
I consent to receiving appointment confirmations, reminders and other health notices via text messages and will update the Practice of any changes to my mobile number		
Signature		Date
Online services - The Practice offers Internet facilities for booking GP appointments and ordering repeat medication online. For access to limited coded medical information please ask reception for a form/check the online section of the practice website. You need to be registered in order to access this service		
Do you want to be registered for the online services?	*Yes / No	***If Yes – please sign the declaration**
Declaration - Please supply me with my User Name and password details to allow me to access the online appointment and repeat medication ordering services. I understand that I am responsible for securing these details to prevent unauthorised persons from accessing my record on line. In the event that my security details have been compromised I will inform the practice immediately so that access can be blocked and a new password issued. If, at any time, I wish to permanently cease Internet access I will inform the practice in writing. I confirm that I have read the terms and conditions and agree to them		
Signature - Patient (or Parent/Guardian)		Date
Name & address of your nominated pharmacy		

Disability & Carers information

Do you consider yourself to have a disability?	*Yes / No	*If yes - please provide details:
Carers – Do you need or do you have anyone who looks after you or your daily needs?	*Yes / No	*If yes - would you like them to deal with your health affairs here? *Yes / No
*If yes, please supply carer's contact name & telephone number		
Do you care for anyone else?	*Yes / No	*If yes - relationship to you
Is this person a patient with the Cherry Hinton and Brookfields Medical Practice	Yes / No	

Medical History
Please detail any current health issues or long term conditions e.g. asthma, diabetes - giving approximate date of onset
Please list any medication you currently take below – including those bought over the counter
Please list any known allergies below

Health Numerics					
Height		Weight			
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 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
Have you ever smoked?	Yes / No	Are you an ex-smoker?		Yes / No **Quit date**:	
Do you currently smoke?	*Yes / No	*If yes, how many per day?			
We strongly advise you to quit smoking. Our Practice Nurses can help or you can contact CAMQUIT: http://www.camquit.nhs.uk or 0800 018 4304					

If you have NEVER been registered in the United Kingdom before please provide details of :
Operations (you have undergone):
Immunisations (you have received):

Family Medical History			
Is there any history of the following in your immediate family - (brothers/sisters/parents)?		**Age at onset**	**Family member affected**
Asthma	Yes / No		
Cancer *site	Yes / No		
Diabetes	Yes / No		
Glaucoma	Yes / No		
Heart Disease	Yes / No		
High Blood Pressure	Yes / No		
Stroke	Yes / No		

Female patients only			
Cervical Screening		**Mammography**	
Have you ever had a cervical smear?	Yes / No	Have you ever had a mammogram?	Yes/No
If yes please give an approximate date		If yes please give an approximate date	
Was the result normal or abnormal?		Was the result normal or abnormal?	
Would you like to receive contraception advice from the Practice?			Yes/ No

Language & Ethnicity – How would you describe your ethnic group? Please circle one					
White	British	Irish	Other white		
Asian	Asian British	Bangladeshi	Indian	Pakistani	Other Asian
Black	Black British	African	Caribbean	Other Black	
Mixed	Asian & White	Asian & Black	Asian & Caribbean	White African	White Caribbean
Other	Chinese	Japanese	Middle Eastern	Turkish	
Any other please specify					
Please give details of your first language:					
If English is not your first language, do you require an interpreter?	Yes / No				

Summary Care Record	
A Summary Care Record is a copy of your key information held in your GP record. With your consent, this information can be shared with other healthcare staff who are treating you, e.g. if you were unexpectedly admitted to hospital they would be able to see some of your problems, medications and allergies. This helps the clinical staff involved in your care make better and safer decisions, and how best to treat you. You can choose what information you would like to share – and with whom. Authorised healthcare staff can only view your Summary Care Record if you have given permission. We are able to share your consent preferences for you - please indicate the level of consent you wish to give by ticking the appropriate box below:	
Express consent for medication, allergies and adverse reactions only	
Express consent for medication, allergies, adverse reactions AND additional information Additional information includes your illnesses and health problems, operations and vaccinations, 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) This is if you do **NOT** want any information shared with other healthcare professionals involved in your care	

We want to hear from you…..
We **really appreciate** your feedback. You can tell us what you think via the NHS choices website www.nhs.uk , via comment cards in the surgery, via our website www.cherryhintonmedical.co.uk. In addition to this, there is the **Friends & Family** questionnaire which can be completed in hard copy in the surgery, or online via our website. It is always great for the staff to hear if you think they are doing a good job (any online feedback will be passed on) and of course if there are any areas you think we could do better, please do get in touch with the Practice Manager. In addition to this we operate an online **PATIENT FORUM** which if you join you will be contacted via email from time to time by the Practice Manager, for your views on any service changes we are considering**.** If you would like to be part of this group please ensure you have added your email address on page one and please sign the declaration below. If at any time you wish to remove yourself from this list, please just let us know. Your details will never be passed to any third party.
Please only sign here if you would like to be part of the online PATIENT FORUM: I would like to add my email address to the online forum mailing list and understand that this will be used to ask me for my opinion about the running of the practice and services offered/changes and will not be passed to any third party.

Signature:	**Date:**

Office use only – only obtain if patient is requesting access to online services

Id: Photo Type _____ Address _____ Other: _____ Staff Initials _____ Date_____

Online account issued YES / NO Named GP : _____ Practice leaflet given: YES / NO