FOXHILL MEDICAL CENTRE- NEW PATIENT CHECK QUESTIONNAIRE (November 2019)

Please complete and return to Reception Date of completion: _____

Please provide as much information as possible. This will allow us to improve the care we provide for you.

Proof of address and Photo ID are required to register, please specify your chosen forms of identification:

1. _____ 2. _____

Examples of identification: Passport, Driver's license, Bus pass ID SEEN BY …….

Examples of proof of address: Utility bill, Bank statement

Where was your last GP surgery? ☐ England ☐ Scotland ☐Wales

Personal Information:

Full Name: _____ D.O.B_____

Current address:

House Name/Number: _____

Road Name: _____

Postcode: _____

How many people reside at this address? _____

Contact information: (please tick preferred contact method)

Email address: _____

Phone number: _____

Home number: _____ Work number: _____

Please specify your preferred contact method: ☐ SMS ☐ Letter ☐ E-mail

Do you consent to receiving SMS messages? ☐ Yes ☐ No

Previous addresses for the last two years with dates (if applicable):

House Name/Number: _____ **House Name/Number: _____**

Road Name: _____ **Road Name: _____**

Postcode: _____ **Postcode: _____**

Date from: _____ Date to: _____ **Date from: _____ Date to: _____**

Nationality: _____ Occupation: _____

Height: _____ Weight: _____

Emergency Contact Details:

(Name) _____ ☐ **(Date of Birth) _____** ☐

(Relationship)_____ ☐ **(Mobile) _____** ☐

(Home) _____ ☐ **(Work) _____** ☐

Is your emergency contact a patient at Foxhill Medical Centre? ☐ **Yes** ☐**No**

Is the above person your Next of Kin? ☐ **Yes** ☐**No**

Please complete the sections which are applicable to yourself/the person you are registering.

If in the previous section you ticked 'No', please give details of your Next of Kin:

Name: **Telephone Number:** **Relationship to you:**

Carer Information:

Are you a carer/Do you look after anyone? ☐ Yes ☐No

If yes, please give details of who you care for and state whether they are a patient of this practice.

Name: _____ **Date of Birth:** _____ **Tel No:** _____

Address: _____ **Registered at Foxhill Medical Centre?** ☐ **Yes** ☐**No**

Do you have any communication difficulties? - E.g. problems with vision, hearing or speech? ☐ **Yes** ☐ **No**

If yes, please give details so we can contact you to ensure our records are accurate: _____

_____

Allergies/Sensitivities:

Please list any Allergies or Sensitivities you have:

_____

_____

Are you a smoker? ☐ **Yes** ☐ **No**

If yes, how many cigarettes per day? _____ Ex-smoker – when did you stop smoking? _____

Would you like our help to stop smoking? ☐ **Yes** ☐ **No** (If yes, we will ask the Stop Smoking Advisor to ring you with more info)

If you have **NEVER** smoked, please tick here: ☐

Do you have any past Medical History/Operations?

- **Asthma** Yes/No
- **Diabetes** Yes/No
- **Heart disease** Yes/No
- **Are you a Veteran?** Yes/No
- **COPD** Yes/No
- **Renal problems** Yes/No
- **Do you have a spleen** Yes/No
- **High blood pressure** Yes/No
- **Cancer** Yes/No
- **Stroke** Yes/No
- **Any Disabilities** Yes/No (enter any further info below)

Further information/other problems:

Do you have and close family medical history? (State which member i.e. mum, dad, brother, sister, son, daughter please)

- **Diabetes** Yes/No (family member_____)
- **High blood pressure** Yes/No (family member_____)
- **High cholesterol** Yes/No (family member_____)
- **Stroke** Yes/No (family member_____)
- **Heart disease of relative diagnosed before they were 60 years of age?** Yes/No (family member_____)
- **Any other conditions? _____** (family member_____)

Please now complete the Sharing and Alcohol sections overleaf and note the online access information.

Summary Care Records:

Summary Care Record (SCR) – this is an electronic record which contains information about the medicines you take, allergies you suffer from and any bad reactions to medicines you have had. Having this information stored in one place makes it easier for healthcare staff to treat you in an emergency, or when your GP practice is closed.

☐ **I agree to opt in**

☐ **I do NOT agree to opt in**

More information about the Summary Care Record can be found in our practice leaflet or on the following website:

https://digital.nhs.uk/services/summary-care-records-scr/summary-care-records-scr-information-for-patients

Sharing information:

It is the medical centre's computer system has two settings to allow you to control how your medical information is shared:

Sharing Out – this controls whether your full GP electronic patient record can be shared with other NHS Care Services where you are treated. This helps the service which you are accessing. Please record your preference below:

Sharing Out: ☐**Yes (shared)** ☐**No (not shared)**

Sharing In – This controls whether you agree for this practice to view information you've agreed to share at other NHS Care Services. This helps the practice see what care you have had elsewhere in the NHS. Please record your preference below:

Sharing In: ☐**Yes (viewable)** ☐**No (not viewable)**

If you require more information regarding this, please ask at Reception for a leaflet, Thank you.

Patient Online registration form – Access to GP online services

You will automatically be given online access to book appointment and order prescriptions when you register.

You are entitled to full clinical electronic record access going forward. Please allow us one week to process your registration.

Please collect your password information from us within 28 days of registration. If this is not collected within six weeks, it will be destroyed and you will need to complete a new application for access. You will be required to bring proof of ID with you when collecting your password.

Childhood vaccination records

If you are registering on behalf of a child that was born outside of the United Kingdom, please provide the practice with a written record of the child's vaccination history.

1 unit is typically:

Half-pint of regular beer, lager or cider; 1 small glass of low ABV wine (9%); 1 single measure of spirits (25ml)

Please use this guide to help you answer the questions below

The following drinks have more than one unit:

A pint of regular beer, lager or cider, a pint of strong /premium beer, lager or cider, 440ml regular can cider/lager, 440ml "super" lager, 250ml glass of wine (12%)

The following questions are validated as screening tools for alcohol use

AUDIT- C 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	
					TOTAL :	

A score of **less than 5** indicates *lower risk drinking* (see overleaf)

Scores of 5+ requires the following 7 questions to be completed:

AUDIT Questions (after completing 3 AUDIT-C questions above)	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	
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	
					TOTAL	