**NEW PATIENT QUESTIONNAIRE**

Please complete this questionnaire as fully as possible. The information will help the health care team to make an initial assessment of your health which will help in your future treatment. It often takes us several months to obtain your medical notes from your previous doctor and the more information we have, the better we can help you.

When you have completed the form, please return it via email to

**nencicb-nt.nelsonmedicalgroup@nhs.net****.** This information will be held in your personal health record which, like all NHS records, remains confidential. For further details about your health records, please see our patient information leaflet.

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| **PERSONAL DETAILS** |
| **Surname:** | **First name(s):** |
| **Previous surname(s):** | **Sex:** Male/female **Title:** Mr/Mrs/Miss/Ms/Dr/Other |
| **Date of birth:** | **Occupation:** |
| **Home address:** |
| **Home tel:** | **Mobile tel:** |
| **Work tel:** | **Email:** |
| *We may occasionally want to contact you to remind you of an appointment.* I consent to be contacted \* by SMS on this number:…………………………………………………………I consent to be contacted \* by email at this address:…………………………………………………………\**It is your responsibility to keep us updated with any changes to your telephone number, email & postal address*.*We may contact you with appointment details, test results, health campaigns, Patient Participation Group details or health information.**If you do not consent to being contacted by SMS or Email, please tick here:* EMAILSMS |

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| **MILITARY SERVICE** |
| **Have you ever served in the Military forces?** Yes /No |
| **PREVIOUS GP DETAILS** |
| **Name of last GP:** | **Telephone:** |
| **Address:** |

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| **HEALTH INFORMATION** |
| **Height:** | **Weight:** |
| **Do you smoke?** Yes/NoCigarettes/cigars/pipe/roll-ups | **If yes, how many per day?** |
| **Have you ever smoked?** Yes/No | **If you have stopped smoking, give approximate date you stopped:** |
| ***We strongly recommend that patients do not smoke****. If you would like advice or help to give up smoking please speak to either your GP, nurse or enquire at reception for details of where to access smoking cessation services.* *If you did smoke, or are a current smoker, have you ever had any medication or patches to help you stop? Yes/No**If yes, please give details:* |
| **Do you have any allergies?** animals/pollen/nuts/medication/other (please specify) |
| **Have you ever suffered from a bad reaction to any medication?** Yes/NoIf yes, please give details: |
| **What prescription or over the counter medication do you currently take?** (If possible please supply a copy of your recent medication.) |
| **What regular exercise do you take?** |
| **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 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 |

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| **SUMMARY CARE RECORD** |
| The Practice is Summary Care Record enabled. If you require further information or wish to opt-out of this service please speak to our receptionist, or visit **www.nhscarerecords.nhs.uk** |
| **PERSONAL MEDICAL HISTORY** |
| **Please give details of any serious illness, accident or special needs, including dates:****Do you attend hospital?** Yes/No**If yes, where?** |

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| **RECENT INVESTIGATIONS AND VACCINATIONS** |
| **Date of first MMR:****Date of second MMR:** | **Date of last Blood Pressure check:** |
| **Date of last Tetanus vaccination:** | **Date last Cholesterol check** |
| **Date of last Flu vaccination:** | **Date of last Cervical Smear** |
| **Date of last Pneumococcal vaccination:** | **Date of Shingles vaccination:** |

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| **CARERS** |
| **Do you look after or support someone who is ill, frail, disabled or mentally ill?** Yes/No |
| **Are you looked after or supported by somebody because you are ill, frail, disabled or mentally ill?**Yes/No |
| *If you answered* ***‘yes’*** *to either of these questions, please ask the receptionist for our carer's form.* |

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| **ACCESSIBLE INFORMATION** |
| **Do you need information in a different format ie braille, large print ?** Yes/No |
| **Do you need a British Sign Language interpreter or advocate?**Yes/No |
| **If you find it hard to read our letters or if you need someone to support you at appointments please let us know.** |

If you have any other health concerns, please discuss them with a nurse or GP.

Thank you for taking the time to complete this questionnaire.

Please also complete our next of kin and ethnic monitoring questionnaire

**ETHNIC CATEGORY QUESTIONNAIRE**

Please indicate your ethnic category. 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 the early identification of some of these conditions.

This form may only be completed by the patient in person, or a parent in the case of a child. It may not be changed by us unless you ask for a change. This information will be added to your computer health record and will remain confidential.

Choose ONE category from A to Z, and then tick the box to indicate your ethnic category. If asked to specify, please do so as fully as possible.

|  |  |  |
| --- | --- | --- |
|  | **White**  |  |
| A | British |  |
| B | Irish |  |
| C | Any other white background (please specify) |  |

|  |  |  |
| --- | --- | --- |
|  | **Mixed** |  |
| D | White & black Caribbean |  |
| E | White & black African |  |
| F | White & Asian |  |
| G | Any other mixed background (please specify) |  |

|  |  |  |
| --- | --- | --- |
|  | **Asian or Asian British** |  |
| H | Indian |  |
| J | Pakistani |  |
| K | Bangladeshi |  |
| L | Any other Asian background (please specify) |  |

|  |  |  |
| --- | --- | --- |
|  | **Black or Black British**  |  |
| M | Caribbean |  |
| N | African |  |
| P | Any other black background (please specify) |  |

|  |  |  |
| --- | --- | --- |
|  | **Other ethnic groups** |  |
| R | Chinese |  |
| S | Any other ethnic group (please specify) |  |

|  |  |  |
| --- | --- | --- |
|  | **Not stated** |  |
| Z | Not stated |  |

Main Language Spoken...........................................................................................

Full Name ……………………………………………………………………………………..

Date of Birth ……………………………………………..……………………………………

Signature ………………………………………………Date………………………………..

**NEXT OF KIN INFORMATION**

Please complete the details below and return to the receptionist.

**PATIENT DETAILS:**

|  |  |
| --- | --- |
| Family Name |  |
| First Names |  |
| EMIS Number |  |

**NEXT OF KIN PERSONAL DETAILS:**

|  |  |
| --- | --- |
| Relationship to Patient |  |
| Title | Mr/Mrs/Miss/Ms/Other |
| Family Name |  |
| First Names |  |
| Gender | Male/Female |
| Date of Birth |  |

**HOME ADDRESS:**

|  |  |
| --- | --- |
| House Name/Flat Number |  |
| House Number and Street |  |
| Locality |  |
| Town/City |  |
| County |  |
| Postcode |  |

**CONTACT DETAILS:**

|  |  |
| --- | --- |
| Home Telephone Number |  |
| Work Telephone Number |  |
| Mobile Telephone Number |  |

**OTHER RELEVANT DETAILS:**

|  |  |
| --- | --- |
| Contact in an Emergency | Yes/No |
| Consent to discuss medical record | Yes/No |
| Any other information |  |