**Dr Perkins Practice**

**New Patient Questionnaire**

To register with this Practice, please complete this questionnaire as fully as possible. The questions have been designed to help your new GP get to know you and your medical history. It may take some time for your previous medical records to reach us. The information you give will help us to provide you with good medical care. All information you provide in this questionnaire is strictly confidential and will be become part of your medical record. Please be assured that Dr Perkins Practice will never pass your details to anyone other than e.g. Hospital Doctor/Midwife/District Nurse or other Medical Professionals involved in your care.

|  |
| --- |
| **PERSONAL DETAILS** |
| Title | Mrs/Miss/Ms/Mr/Dr | Have you been registered here before? | Yes No  |
| Surname |  | Previous Name |  |
| Forename(s) |  | Address |  |
| Date of Birth |  |
| NHS Number |  |
| Home Tel. No. |  | Post Code |  |
| Mobile Tel. No. |  | Email |  |
| Name of School/College: |  |
| Next of Kin |  | Relationship |  |
| Contact No. |  | Address |  |
| Status | Single  Married  Separated  Divorced  Widowed  Cohabitating  |
| Which of the options best describes you? | Hetrosexual or Straight  Gay or Lesbian  Bisexual   |
| Which of the following best describes you? | Female (including trans women)  Male (inluding trans men)  Non-Binary  |
| Is your gender identity the same as the gender you were given at birth?  | Yes  No  |
| What is your employment status? | Student  In Employment  Full Time Employment  Part time Employment Unemployed  Recent Unemployment  Chronic Unemplyment  Unfit for Work  Housewfife  Househusband Retired Early Retirement Medically Retired  |
| What is your Occupation? |  |
| **Where possible please provide proof of identity and address.** * Proof of identity to include Passport/Birth Certificate
* Proof of Address to include Utility Bill/Legal Document (not older than 1 month)
 |

|  |
| --- |
| **Health Details** |
| Height |  m | Weight |  kg |  |
| **Drugs :**  | Do you have a drug addiction? | Yes  No  |
| Are you a smoker? | Yes  No  | How many a day?  | Never smoked? | Yes  No  |
| Would you like support and/or information on giving up? | Yes  No  (Positive Steps 0161 621 9400) |
| Stopped smoking? | Yes  No  | When? And Age |  |
| Passive Smoking | Are you exposed to smoke at work?  | Yes / No | At home? Yes / No |
| Do you take regular exercise? | Yes  No  | If Yes what sort? How many times a week |  |

|  |
| --- |
| **Medical History**Do you have, or have you had, any serious health problems (including operations) / long term conditions? |
|  |  | Details | Date (if known) |
| Asthma |  |  |  |
| Cancer |  |  |  |
| COPD |  |  |  |
| Chronic kidney disease |  |  |  |
| Diabetes |  |  |  |
| Epilepsy  |  |  |  |
| Heart attack / disease |  |  |  |
| High cholesterol |  |  |  |
| Osteoporosis  |  |  |  |
| Stroke  |  |  |  |
| Mental health problems  |  |  |  |
| Underactive thyroid |  |  |  |
| Circulation problems |  |  |  |
| Other serious illness |  |  |  |
| Any operations |  |  |  |
|  |  |  |
| Any known allergies | Yes  No  | Allergic to |  |
| Details of the reaction |  |
| Do you carry an Epi pen? | Yes  No  |

**Confidentiality / Data Protection** – Practice staff are bound by contracts of employment to maintain confidentiality. We hold your patient records in the strictest confidence, regardless of whether they are electronic or on paper. We take all reasonable precautions to prevent unauthorised access to your records, however they are stored. Any information that may identify you is only shared with the practice team, or, if you are referred to hospital, to the clinician who will be treating you. We will only share information about you with anyone else if you give your permission in writing.

|  |
| --- |
| **Repeat Medication** |
| Are you on any repeated medication? | Yes  No  |
| If “Yes”, do you have a repeat prescription slip from your previous GP? | Yes  No  |
| If “Yes”, please hand it in at Reception. If “No” then list below any current medication you are taking and make sure you show Reception all your medication in its original packaging and labelling. We may need to contact your previous GP surgery to confirm your medication. |
| *Name of drug* | *Frequency (how often taking it)* | *Reason for using drug* |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |
| --- |
| **Family Medical History**Have any of your immediate relatives (brothers/sisters/parents) had any of the following:*Tick box if applicable and give details if you can.* |
|  |  | **Details** | **Relationship**  | **Date (*if known)*** |
| Heart attack or angina before age 60 |  |  |  |  |
| Heart attack or angina over age 60 |  |  |  |  |
| Asthma  |  |  |  |  |
| Cancer |  |  |  |  |
| Diabetes  |  |  |  |  |
| DVT/Thrombosis  |  |  |  |  |
| Glaucoma |  |  |  |  |
| Hypertension |  |  |  |  |
| Osteoporosis |  |  |  |  |
| Stroke |  |  |  |  |
| Any inherited diseases |  |  |  |  |

|  |
| --- |
| **Smear/ Family Planning** |
| Date of last cervical smear? |  | Are you pregnant?  | Yes  No  |
| Have you had a hysterectomy? | Yes  No  |  |
| Contraception – what is your current method of family planning? |
| None |  | Coil  |  | Injection  |  |
| Contraceptive Pill |  | Sterilisation  |  | Implant  |  |
| Condom |  | Partner had vasectomy |  | Hysterectomy  |  |

|  |
| --- |
| **Ethnicity -** How would you describe your ethnicity? |
| **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   | Other Ethnicity  |
| Please advise us of your First Language | English  | Other (please state)  |  |
| **Please advise if you require an interpreter?**  | Yes / No |  |  |
|  |
| **Military Veteran – Please tick below if you have provided a service as a veteran. If yes please tick if you consent for this to be noted on your medical records**  |
|  | Army (13Ji0)   | Royal Air Force (13Ji1)  | Royal Navy (13Ji2)  | Royal Marines(13Ji3)  |  |
| **Carers**  |
| Do you look after the daily needs of someone else? (*Office use only:918G*) | Yes  No  |  |
| Do you have someone who looks after you or your daily needs? (*office use only 918F*) | Yes  No  |  |
| *If the answer to either of the above questions is YES and you would like us to record their details and the nature of their relationship to you, please complete the section below.*  |
| **I am the carer and I care for / I am cared for by (*please delete as appropriate)*** |
| **Name** |  | **Telephone No** |  |
| **Address & Postcode** |  | **Email**  |  |
| **Nature of relationship** |  |

|  |  |  |
| --- | --- | --- |
| Do you wish to register for online appointment booking / prescriptions/see your GP records?  | Yes  No  | If **YES** Please provide email address on page 1 |
| Can the practice contact you from time to time about practice services and developments  | Yes  No  | If **YES** Prefered method of contact? Mobile Email Landline |
| (*office use only: can contact via email – 9NdS*) |
| Can we send you text reminders to your mobile for appointments booked with the surgery? (*office use only: 9NDP*) | Yes  No  |
| **Your named GP will be Dr Perkins** |

|  |  |
| --- | --- |
| **FOR OFFICE USE ONLY****Receptionist Check List**  | **Staff Initials & Date** |
| GMS1 – Correctly completed (**including NHS Number)**, signed and dated by patient or patients representative |  |
| Summary Care Record Paperwork - Correctly completed, signed and dated by patient or patients representative |  |
| Proof of Address (no older than 1 month) (evidence seen where possible)  |  |
| Photo ID (evidence seen where possible) |  |

**AUDIT – C**

|  |  |  |
| --- | --- | --- |
| **Questions** | **Scoring system** | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink containing alcohol? | Never | Monthlyor 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 |  |

**Scoring:**

**SCORE**

A total of 5+ indicates increasing or higher risk drinking.

If 5 + please fill in the Remaining Audit Questions on the next page.

**AUDIT questions**

|  |  |  |
| --- | --- | --- |
| **Questions** | **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 |  |

**Scoring:** 0 – 7 Lower risk, 8 – 15 Increasing risk,

**TOTAL = =**

 16 – 19 Higher risk, 20+ Possible dependence

TOTAL Score equals

AUDIT C Score (above) +

Score of remaining questions

|  |
| --- |
| **Alcohol - Alcohol use can affect your health and can interfere with certain medications and treatments.****Your answers will remain confidential so please be honest.**  |