New Patient Medical Questionnaire

Please provide photo ID and proof of address □

Please complete as accurately as you can. All information will be kept strictly confidential. If you need any help, please ask at reception. If you are taking regular medication or have long term medical conditions please make an appointment at reception for a new patient check with one of our nurses.

NAME: ..... **DATE OF BIRTH:** .....

TELEPHONE NUMBER: ..... **MOBILE NUMBER:** .....

If you provide your mobile number you will be enrolled for our text message reminder service. From time to time we may also text you with other important information.
To opt out of text message reminders please tick here □

HEALTH INFORMATION

WEIGHT: ..... **HEIGHT:** ..... (ask at reception if you need to be weighed/measured)

DO YOU SMOKE? YES / NO IF **YES** – HOW MANY PER DAY? .....

Would you like help giving up smoking? **YES / NO** (please make an appointment for smoking cessation with the nurse)

IF **NO** – HAVE YOU EVER SMOKED? **YES / NEVER** DATE STOPPED SMOKING**:** .....

BLOOD PRESSURE

Please take your blood pressure using the automatic waiting room blood pressure machine. Full instructions are given.

Please hand the printout in with this form. **BP** ...../.....

MEDICAL HISTORY

DO YOU SUFFER WITH ANY OF THE FOLLOWING MEDICAL CONDITIONS?

ASTHMA ☐ HEART DISEASE (eg ANGIINA, HEART ATTACK) ☐ STROKE ☐

DIABETES ☐ HYPERTENSION (HIGH BLOOD PRESSURE) ☐ EPILEPSY ☐

DO YOU HAVE ANY OTHER MEDICAL CONDITIONS? YES / NO (please list) .....

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DO YOU TAKE ANY REGULAR MEDICATION? YES / NO (please list) .....

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IF YOU ARE TAKING REGULAR MEDICATION, PLEASE BOOK APPOINTMENT WITH NURSE PRACTITIONER

APPOINTMENT BOOKED (10 mins with HW) ☐ date/time .....

DO YOU HAVE ANY DRUG ALLERGIES? YES / NO (please list) .....

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If you are age 40 – 74 and have no pre-existing medical conditions you are entitled to a free NHS Health Check. Please book this at Reception.

PREFERRED CHEMIST NAME: ..... **LOCATION:** .....

Please specify name and location of chemist as all prescriptions will be sent electronically to your preferred chemist
If you would prefer to collect your prescription from the surgery, please tick here □

ALCOHOL CONSUMPTION

Question	Scoring System					Your score
	0	1	2	3	4	
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	

CERVICAL CYTOLOGY *(FEMALE PATIENTS ONLY)*

DATE OF YOUR LAST SMEAR TEST? .....

CARERS

ARE YOU CARED FOR BY SOMEONE EITHER ON A FULL OR PART TIME BASIS? **YES / NO**

Carer Details: Name .....Contact Number .....

Relationship .....

DO YOU CARE FOR SOMEONE EITHER ON A FULL OR PART TIME BASIS? **YES / NO**

FOR CARERS SUPPORT: **SOUTH WARWICKSHIRE CARERS' SUPPORT SERVICE** - 0845 600 9980

NEXT OF KIN DETAILS

NAME: ..... TEL NO: ..... RELATIONSHIP: .....

ADDRESS: .....

OCCUPATION / STUDENT - PLEASE SPECIFY .....

ETHNIC ORIGIN

In compliance with the Race Relations (Amendment) Act 2000 and its Race Equality Scheme any new patient registrations are requested to complete this form. Please tick the appropriate box to indicate your ethnic origin:

○ British or mixed British
○ English
○ Irish
○ Scottish
○ Welsh
○ Any other (specify if you wish)

Black
○ African
○Caribbean
○ Any other black background (specify if you wish)

Mixed ethnic background
○ Asian and white
○ Black African and white
○ Black Caribbean and white
○ Any other mixed ethnic background(specify if you wish)

Asian
○ Bangladeshi
○ Indian
○ Pakistani
○ Any other Asian background (specify if you wish)

Chinese
○ Any Chinese background (specify if you wish)

White
○ Any white background (specify if you wish)

Any other ethnic background
○ Any other ethnic background (specify if you wish)

WHAT IS YOUR MAIN SPOKEN LANGUAGE? .....

ONLINE SERVICES REGISTRATION

We are pleased to offer our patients the ability to book appointments and order repeat medication online 24 hours a day, 7 days a week. You can register for this service by visiting our website **www.lislecourt.co.uk** or ask at reception for details. Please allow one week from registering with the surgery before registering for this service.

PATIENT PARTICIPATION GROUP

We have a patient participation group who meet with the practice three times a year. This group provides an effective way for patients and the surgery to work together to improve services and to promote health and improved quality of care.
If you are be interested in joining the group please tick here and we will contact you prior to our next meeting □

SUMMARY CARE RECORD SERVICE

When registering with a new gp in the uk you are **automatically enrolled** for an nhs electronic summary care record. A summary care record contains information about the medicines you take and any allergies you suffer from.
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.
It is easy to opt out of having a summary care record, simply ask at reception for an opt out form or visit: www.nhscarerecords.nhs.uk/optout

OFFICE USE ONLY:

Informed of Named GP: NM / TB

On medication / Chronic Diseases - Appointment booked with HW

Age 40-74 (no statin or chronic diseases) - Appointment booked with SH/VF

Age 75 or over – Appointment booked with JW

PH – Appointment booked with JW/AL

DATE: **INITIALS:**