CHILCOTE SURGERY

NEW PATIENT REGISTRATION & HEALTH QUESTIONNAIRE

Appointments & general enquiries - (01803) 316333

www.chilcotesurgery.co.uk

Please complete this questionnaire as fully as possible. The information will help your new GP to make an initial assessment of your health which will help in your future treatment. All the information you provide in this questionnaire is strictly confidential and will form part of your medical record.

Accessible Information Standard

For patients with information or communications needs relating to a **disability, impairment or sensory loss**, please tell us if you **need** information in a different format or communication support.

☐ Braille ☐ British Sign Language ☐ Easy Read ☐ Large Text ☐ Email or Text

Other (Please give details)

Personal Details:

Title: Mr Mrs Miss Ms Other			**Surname:**	
Date of Birth:			**First Names:**	
NHS No:			**Previous Name(s):**	
Male / Female:			**Town and Country of Birth:**	
Home Address:	Postcode:		**Marital Status:**	
Home Telephone No:				
Mobile Telephone:				
Email:				
(for office use) **ID Seen:**	Passport	Driving Licence	Birth Certificate	Other
(for office use)	*Please record passport no. etc*			

Please note: By supplying us with your telephone number and email address, you are giving us permission to use them to send you appointment reminders, invitations and practice information. If you later do not wish to receive contact by email, please tell a staff member, write to us or email us at chilcote.surgery@nhs.net. Please also tell us if any of your contact details change.

Emergency Contact Details:
Next of Kin

Please provide the name and contact details of the person we should contact in case of an emergency. Your medical details will not be shared with this person unless you give permission.	
Name and address of next kin	
Telephone Number	
What relationship is this person to you?	

If you are from abroad

Your first UK address where registered with GP:	
If previous resident in the UK date of leaving	
Date you first came to the UK:	

Ethnic Origin

White:
- ☐ British
- ☐ Irish
- ☐ Other (please specify)

Black:
- ☐ British
- ☐ Caribbean
- ☐ African
- ☐ Other (please specify)

Asian:
- ☐ British
- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Other (please specify)

Mixed Ethnic Group:
- ☐ White/Black Caribbean
- ☐ White/Black African
- ☐ White / Asian
- ☐ Other (please specify)

Other Ethnic Groups:
- ☐ Chinese
- ☐ Japanese
- ☐ Other (please specify)

☐ I do not wish to state my ethnicity

What is your first spoken language:

Carer Questionnaire

Do you look after a disabled/ill person in an unpaid capacity? Yes ☐ No ☐	
If Yes, who do you look after?	
Would you like to be put in contact with our Carers Support Worker? Yes ☐ No ☐	
Does someone look after you? Yes ☐ No ☐	
If yes, what relationship is this person to you?	
Details of your carer	
Title	
Surname	
Forename	
Address of carer	
Postcode	
Telephone	
Email	

If you consent to your carer being informed of your medical information held by the surgery, please tick here ☐ If you later wish to withdraw this consent, please tell a staff member, write to us or email us at chilcote.surgery@nhs.net.

Current Medications:

Please list any medication you are currently prescribed or enclose a prescription form from your previous Doctor's surgery.

Medication Name	Dosage	Frequency

Continue on a separate sheet if necessary.

Prescriptions and nominated pharmacy:

My nominated pharmacy; _____

Our practice routinely prescribes electronically. This means that when your prescription has been requested, it will be sent electronically to your chosen pharmacy. This saves time for you, your Doctor and your Pharmacist. A full list of pharmacies in your local area can be found on the NHS Choices website. Please be aware that certain medications can not be prescribed electronically. Paper prescriptions will be printed for these medications.

You are also able to order your repeat medications online, amongst other things. To register for this service, please see flyer enclosed.

Do you have any known allergies (such as antibiotics, latex, peanut, aspirin) please list them here and describe how the allergy affects you?	

For females aged 15-65 – if you use any form of contraception please circle which one.				
Coil	Depot Injection	Implant	Oral Pill	Patches
Other please give details.				

If you do use contraception, when was your last check-up/review with GP or nurse?	Date:
If you have a Coil or Implant approximately what date was it fitted?	Date:
If you have depot injections when was your last one?	Date:
Have you had a recent smear?	Date:

Health Questionnaire

Please tick if you have a history of any of the following medical conditions:

Cancer, please state site		Coronary Heart Disease, Heart Failure or Atrial Fibrillation	
Dementia or Alzheimer's		Depression or Mental Health	
Hypertension (High Blood Pressure)		Kidney Disease	
Respiratory Difficulties (Asthma or COPD)		Stroke	
Diabetes		Learning Difficulties	
Epilepsy		Thyroid Disease	
B12 deficiency		Hypothyroidism	
If you have any other history **(including operations)** or important illnesses or disabilities not mentioned above please give details below:			

Family History

Is there any history of the following in your family (Father, Mother, Brother or Sister)?			
Heart disease before age 60 (heart attack, angina)	Yes/No	Which family member?	
Stroke	Yes/No	Which family member?	
Diabetes	Yes/No	Which family member?	
Cancer	Yes/No	Which family member?	
Site of cancer			

In the average week how many units of alcohol do you drink? _____

Alcohol Consumption – If you are aged 16 years or over, please complete this alcohol questionnaire

Questions	Score 0	Score 1	Score 2	Score 3	Score 4	Your Score
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 Score	

*****If your score is equal to or greater than 5, please also answer the following questions*****

Questions	Score 0	Score 1	Score 2	Score 3	Score 4	Your Score
How often in the last year have you found you were not able to stop drinking once you have started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you had the feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you not been able to remember what happened the night before when drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or someone 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/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total Score	

*****If your audit score is equal to or greater than 8, please also answer the following questions*****

1. **During the last month have you been feeling down, depressed or hopeless? Yes/No**
2. **During the last month have you often been bothered by having little interest or pleasure in doing things? Yes/No**

If you are concerned about your current alcohol consumption and would like some advice about how to cut down on your drinking please book a routine appointment with a GP

Your Smoking Status

Never Smoked		N/A	
Ex-Smoker		Date stopped	
Cigarette Smoker		How many per day?	
Roll own cigarettes		How many per day?	
Cigar smoker		How many per day?	
Pipe Smoker		How many ounces per week?	
Do you want to stop smoking? Yes ☐ No ☐			

Military Veterans

Have you ever served in HM armed forces, even if only for one day?	Yes ☐ No ☐
If so, which branch?	
If 'Yes', you may be entitled to some prioritization of health care should you develop a problem that may relate to your military service. Do you wish us to specifically record your veteran status in your medical record? (If 'No', please note that we cannot guarantee that there will be no record of your veteran status, however, this will not be specifically recorded and flagged on your medical records. If at any time in the future you develop a problem that you feel may relate to your military service, please notify your GP of this in order that your care can be prioritised. If you develop a significant medical problem that may relate to your military service, you may also wish to apply for a war pension.	Yes ☐ No ☐
Are you a reservist?	Yes ☐ No ☐

Please note that we welcome your feedback, especially if you are not happy about anything.

Declaration

I declare to the best of my knowledge the information I have provided on this form is correct.

Patient Signature:_____ **Date:**_____