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.

What is your preferred method of communication?

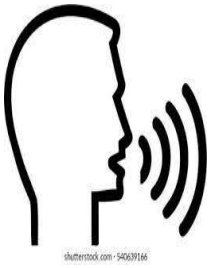
☐ British Sign Language

☐ Makaton

☐ Braille

☐ Letter or Email

☐ Easy Read



☐ Speech

☐ Via a carer

☐ Large Text

☐ Audio

☐ Text message

Other (Please give details)

Personal Details

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Surname:	
First Names:	
Date of Birth:	
Previous Name (s):	
NHS No:	
Gender Identity:	
Home Address:	
Marital Status:	
Home Telephone Number:	
Mobile Telephone: **Email Address:**	

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 either of these methods, 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.

(for office use) ID Seen:	Passport	Driving Licence	Birth Certificate	Other
(for office use)	Please record passport no. etc			

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 of kin	
Telephone Number	
What relationship is this person to you?	

Ethnic Origin

Having information about patients' ethnic groups would be helpful for the NHS so that we can plan and provide culturally appropriate and better services to meet patients' needs.

If you do no wish to provide this information you do no have to do so.

White:

☐ British

☐ Irish

☐ Other (please specify)

Black:

☐ British

☐ Caribbean

☐ African

☐ Other (please specify)

Asian:

☐ British

☐ Indian

☐ Pakistani

☐ Banglasdeshi

☐ 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

If you are from abroad	
In which country were you born?	
Your first UK address where registered with GP:	
If previous resident in the UK date of leaving	
Date you first came to the UK	

Main Language	
What is your first spoken language?	
Do you speak English?	
Do you need an Interpreter?	

Please select your religion	
Church of England	
Catholic	
Other Christian	
Buddhist	
Hindu	
Muslin	
Sikh	
Jewish	
Jehovah's Witness	
No religion	
Prefer not to state	

Free TB Screening (Eligibility Form)

This form will help determine if you are eligible for a FREE TB test. For more information on the TB programme please see www.thetruthaboutttb.or/latent-tb

Please complete all questions, unless you have circled No to question 2 or 3.

1. Please write your country of birth

2. Have you lived in the UK for less than 5 years? ☐ Yes ☐ No

3. Have you lived in any of the below countries for 6 months or more? ☐ Yes ☐ No

4. Are you between the ages of 16-35? ☐ Yes ☐ No

If you have answered yes to Questions 2 and 4 or 3 and 4, please continue, if you have answered No to any of the above questions you do not have complete the rest of this form.

5. Are you from/did you move to the UK from one of the following countries, listed below and on the following page? Yes/No (Please circle)

Afghanistan	Djibouti	Madagascar	Republic of Moldova
Angola	Equatorial Guinea	Malawi	Rwanda
Bangladesh	Eritrea	Mali	Sao Tome and Principe
Benin	Ethiopia	Marshall Islands	Senegal
Bhutan	Gabon	Mauritania	Seychelles
Botswana	Gambia	Mauritius	Sierra Leone

Burkina Faso	Ghana	Micronesia	Somalia
Burundi	Greenland	Moldova	South Africa
Cote d'Ivoire	Guinea (Republic of)	Mongolia	South Sudan
Cabo Verde	Guinea-Bissau	Mozambique	Swaziland
Cambodia	Haitia	Myanmar (Burma)	Timor-Leste
Cameroon	India	Namibia	Togo
Central African Republic	Indonesia	Nepal	Tuvalu
Chad	Kenya	Niger	Uganda
Comoros	Kirbati	Nigeria	Tanzania
Congo	Laos PDR	Pakistan	Zambia
DRP Korea	Lesotho	Papua New Guinea	Zimbabwe
DR Congo	Liberia	Philippines	

6. If you were born in one of the countries above:

Do you have a bad cough? ☐ Yes ☐ No

Do you sweat a lot at night? ☐ Yes ☐ No

Have you lost a lot of weight in the last year? ☐ Yes ☐ No

Specific Needs

Do you have an impairment, health condition or learning difference that has a substantial or long term (over a year) impact on your ability to carry out day to day activities? (Tick all that apply)

☐ No know impairment, health condition or learning difference

☐ A long standing illness or health condition such as cancer, HIV, diabetes, chronic heart disease, asthma or epilepsy?

☐ A mental health impairment, such as depression, schizophrenia or anxiety disorder?

☐ A physical impairment or mobility issues, such as difficulty using your arms or using a wheelchair or crutches and would need help with access to premises?

☐ Do you have an assistance dog? ☐ Yes ☐ No

☐ Do you have any phobias? ☐ Yes ☐ No

Please state:	

☐ Do you need help with an advocate? ☐ Yes ☐ No

Do you have significant mobility issues? ☐ Yes ☐ No

If yes, are you housebound?
(Definition of housebound – a patient is unable to leave their home due to physical or psychological illness)

☐ A learning difficulty

☐ Neuro-diverse e.g. dyslexic, dyspraxia or AD(H)D

☐ Deaf or hearing impaired

Do you have significant problems with your hearing? ☐ Yes ☐ No

Blind or have a visual impairment uncorrected by glasses ☐ Yes ☐ No

Are you blind/partially sighted ☐ Yes ☐ No

☐ An impairment, health condition or learning difference that is not listed above?

Please state:	

☐ Prefer not to say

Military Veterans

As a practice, we fully support the Armed Forces Covenant. We can only do this if we know our patients connections to the Armed Forces. Please tick below that applies to you.

I am a Military Veteran		I am currently serving in the Reserve Forces	
I am married/civil partnership to a serving member of the Regular/Reserve Armed Forces		I am married/civil partnership to a Military Veteran	
I am under 18 and my parent(s) are serving member(s) of the Armed Forces		I am under 18 and my parent(s) are veteran(s) of the Armed Forces.	

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 records? (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.

Do you wish us to specifically record your veteran status ☐ Yes ☐ No

Carer Questionnaire

Do you look after someone who can't manage without you? ☐ 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	
D.O.B	
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 Medication

Please list any medication you are currently prescribed or enclose a prescription for from you 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 cannot be prescribed electronically. Paper prescriptions will be printed for these medications.

You are also able to order your repeat medications online, via Patient Access or the NHS App as well as emailing our prescription team directly on L83111.prescriptions@nhs.net

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

For females ages 15-65 – if you use any form of contraception please circle which one				
Coil	Depo 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 depo 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?	

Stoke ☐ 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 day?	
Do you want to stop smoking, please contact Healthy Lifestyles Team on 0300 456 1006			