The Elmhurst Practice

New Patient Questionnaire

Personal Details

We require the following information to help us when you register with the practice..

Your registration is not complete until this form is completed and returned to reception.

Title: ……. Surname: …… Forenames: ……

Date of birth: …….. Sex: M/F Marital status: ……

Address: ……

…….. Postcode: ……

Home Tel: …… Mobile: ……Work: ……

Occupation: ……

Ethnicity: …….. Religion: ……

Next of kin details:

Surname: …….. Forename: ……

Address: ……

……. Postcode: ……

Home Tel: ……. Mobile …….. Work: ……

Would you like them to deal with your health affairs here? Yes/No
(If yes please ask the receptionist for details of how this can be arranged).

If you are from overseas what date did you arrive in the UK? ……...

Languages spoken …… Main language spoken……..

Do you speak English well? Yes/No

Date of completion of this form ……..

IMPORTANT!

Summary Care Records

Would you like to have a summary Care Record (SCR)? SCR is a brief summary of your clinical information, which will be accessed by authorised clinicians in the event of urgent or emergency care.

Yes ☐ **No** ☐

Personal Social History

Smoking

Do you smoke? Yes [ ] No [ ]

If yes, would you like to make an appointment with one of our nurses in our stop smoking clinic Yes [ ] No [ ]

Cigarettes per day…….. Cigars per day ……. Ounces of tobacco per day…….

Ex Smokers

What date did you stop smoking: …….....

Are you still a non smoker? Yes [ ] No [ ]

Diet

Do you eat a healthy diet? Yes [ ] No [ ]
(Recommended: 5 portions of fruit & vegetables per day and 8 glasses of water per day)

Exercise

Do you take regular exercise? Yes [ ] No [ ]

If yes, what sort of exercise? ……..

How many times per week? ……

Alcohol

For the following questions please √ the answer that best applies. One (1) drink = ½ a pint of beer or **1** glass of wine or **1** single spirit					
How often did you have a drink containing alcohol in the past year?	Never [ ] 0	Monthly or less [ ] 1	2 to 4 times a month [ ] 2	2 to 3 times per week [ ] 3	4 or more time per week [ ] 4
How many drinks did you have on a typical week day when you were drinking in the past year?	1 or 2 [ ] 0	3 or 4 [ ] 1	5 or 6 [ ] 2	7 or 9 [ ] 3	10+ [ ] 4
How often did you have 6 or more drinks on one occasion in the past year?	Never [ ] 0	Monthly or less [ ] 1	Monthly [ ] 2	Weekly [ ] 3	Daily or almost daily [ ] 4
Audit C total **Practice only to complete**					

Personal Medical History

Weight: …… Height: ……

Do you suffer from or are you receiving treatment for any of the following conditions?

Diabetes:	Yes/No	Year of diagnosis…….. ……..
Glaucoma:	Yes/No	Year of diagnosis……..
Asthma/COPD:	Yes/No	Year of diagnosis……. ……. …….
Cancer :	Yes/No	Year of diagnosis……..
High blood pressure:	Yes/No	Year of diagnosis……. ……
Stroke:	Yes/No	Year of diagnosis……..
Heart attack/Angina:	Yes/No	Year of diagnosis…….. ……
Mental Illness:	Yes/No	Year of diagnosis……
Thyroid Problems:	Yes/No	Year of diagnosis……
Epilepsy:	Yes/No	Year of diagnosis……
Are you a carer?	Yes/No	If yes who do you care for? …….
Do you have a carer	Yes/No	If yes how often? ……..

If you have a carer please give their details:

Name…….. Address……

……. Postcode……

Tel No. ……

Would you like them to deal with your health affairs here? Yes/No
(If yes please ask the receptionist for details of how this can be arranged).

Do you have any allergies? Yes [ ] No [ ]

If yes please give name of any drugs you are allergic to: …….

Any other allergies please give details …….

Do you suffer from hay fever? Yes [ ] No [ ]

If yes what medication do you take for this ……

What operations have you had? (Please give details if possible)

……

……

Have you had any medical problems in the past? Please specify

……

……

Medication

Please give details of any medication which you take (prescribed or otherwise) So we can ensure we see the correct medication from your previous GP please attach a repeat medication request form if you have one.

Name of medication **Dosage**

Name of medication	**Dosage** **i.e. 10mg, 20mg etc**	**Frequency** **i.e. 1daily, twice day etc**

Please note

If you are on regular medication needing a prescription, please be aware you will not be able to get a prescription until you have seen a doctor. Please remember to make an appointment.

Family History

Is your father alive Yes [ ] No [ ]

If no please give details ……..

Is your mother alive Yes [ ] No [ ]

If no please give details ……..

Is there any of the following in your family (*father, mother, brother, sister, grandparent, aunt/uncle)*

Heart attack Yes/No Which family member? ……

Asthma Yes/No Which family member? ……

Stroke Yes/No Which family member? ……

High Blood pressure Yes/No Which family member? ……

Diabetes Yes/No Which family member? ……

Raised Cholesterol Yes/No Which family member? ……

Cancer Yes/No Which family member? ……

Site of cancer……..

Any other relevant family history:

……

……

Immunisations

Have you been immunised against:

Tetanus	Yes/No/Unsure	If yes, date ……
Polio	Yes/No/Unsure	If yes, date ……
Diptheria	Yes/No/Unsure	If yes. Date ……...
Meningitis C	Yes/No/Unsure	If yes, date ……
Have you had **2 MMR** injections	Yes/No/Unsure	If yes, date …….
		date…….

Have you had any travel immunisations? If yes please attach vaccinations and dates

Female Patients Only

Have you ever had a smear test? Yes [ ] No [ ]

If yes, please give result and date of last test …….

If you are over 50 years of age, have you had a breast mammogram? Yes [ ] No [ ]

If yes, pleas give result and date ……...

Contraception

Do you use contraception? Yes [ ] No [ ]

The pill	Yes/No	If yes what is it called: …….....
Coil	Yes/No	If yes when was it inserted: ……..
Condoms	Yes/No	
Cap/Diaphragm	Yes/No	If yes how long have you had this Cap/diaphragm …….
Depo Injection	Yes/No	If yes, what date is your next injection due …….....
Have you been sterilised		Yes/No
Has your partner had a vasectomy		Yes/No

Thank you for completing this questionnaire. It will take up to 2 working days for your registration to be processed.

Patient Reference Group

Following The Department of Health's recent release of details to improve patient participation our Patient Participation Group Friends of Elmhurst are encouraging patients to give their views about how the practice is doing. As such we are proactively promoting engagement of our patients through a Patient Reference Group. The key objectives of this are to:

- Agree areas of priority with their patient reference group
- Collate patient views through a patient survey
- Publicise the results of the patient survey
- Agree an action plan with their patient reference group

Friends of Elmhurst would like to be able to ask the opinion of as many patients as possible and are asking if people would like to provide their email address so that they can contact you every now and again to ask a question or two.

Are you interested in leaving your email address?

If you could fill in this quick form and hand it back to reception we will pass your contact details to the Patient Participation Group.

Name……. Email address: _____

Your contact details will only be used for this purpose and will be kept safely.