NEW PATIENT QUESTIONNAIRE 16+

Please fill in all relevant pages

Title:________**Surname:**____________________**Previous Surname:**_________________________

Forename(s)___________________________________ **Sex:** Male Female (circle)

Marital Status: Married / Single / Divorced / Separated / Widowed (Circle) **D.O.B** ___________________

Home Tel: _______________________________ **Mobile:** _________________________________

Email: ____

Next Of Kin: Name:___________________________**Relationship:**______________________

Contact No: _______________________________________

***Are you* an unpaid carer for a child or adult with a disability or enduring illness?** Y/N (Circle)
Are you cared for? Y/N (circle)
If yes please ask at reception for a carer registration pack

Do you work as a Carer? Y/N (Circle) **If yes, are you a live-in carer?** Y/N (Circle)

I am a military Veteran? Y/N (Circle) **I am an immediate family member of a Military Veteran?** Y/N (Circle)

I already use EPS and want to continue to use the following pharmacy: ________________________________

I Consent to using the Electronic Prescription Service: Y/N (Circle)
Please send my prescriptions to the following pharmacy: _____________________________________

Patient Ethnic Origin Questionnaire

This questionnaire follows the recommendations of the *Commission for Racial Equality* and complies with the Race Relations Act. Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

Please record the MAIN SPOKEN language you use: ☐ ☐ ________________________________

I require a language interpreter **I require a BSL interpreter**

A) WHITE	British #9i0	Irish #9i1	Any other white back ground: #9i2	
B) MIXED	White & Black Caribbean #9i3	White and Black African #9i4	White and Asian #9i5	Any other mixed background #9i6
C) ASIAN OR ASIAN BRITISH	Indian #9i17	Pakistani #9i8	Bangladeshi #9i9	Any other Asian background #9iA
D) BLACK OR BLACK BRITISH	Caribbean #9iB	African #9iC	Any other black background:9iD	
E) CHINESE OR OTHER ETHNIC GROUP	Chinese #9iE	Any other ethnic group #9iF		
F) DECLINED	#9SD			

Measurements

Height:____________________Weight: ______________

MEDICAL HISTORY: *Please list all significant medical problems where possible, e.g.*

Major Operations, Diabetes, Asthma, Heart Disease, Strokes

FAMILY HISTORY *Have any of your Parents, Brothers or Sisters suffered from Heart Disease, Diabetes, Asthma, High Blood Pressure or Strokes? If yes, please give their ages, relationship to you and age at diagnosis:*

PROBLEMS : *Please list any active problems including dates*

MEDICATION : *Please list all medication you are currently taking*

ARE YOU ALLERGIC TO ANY DRUGS:

Vaccinations :

Date of Last Tetanus:_______________ Flu Vaccination:_____________

Date of COVID Vaccination 1:_____________Location: __________________Which Vaccine:_____________

Date of COVID vaccination 2:_____________ Location:__________________ Which vaccine:_____________

SOCIAL HISTORY:

Do you Smoke? Y/N (Circle)
**We recommend that you do not smoke. Ask at Reception about the 'Quit Smoking Clinics'*

If yes, how many cigarettes do you smoke each day? ____________

If no, have you ever smoked? Yes / No   and approximately when did you stop? __________

Do you use a Vape/Electronic cigarette? *Y/N (Circle)*

Exercise (please tick)

Exercise impossible ☐ Light Exercise ☐ Moderate Exercise ☐ Aerobic Exercise ☐

Diet (please tick)

Vegetarian ☐ Vegan ☐ Weight Reducing ☐ Low Fat ☐ Low Salt ☐

Milk Free ☐ High Fibre ☐ Normal ☐

ALCOHOL

How many units of alcohol do you drink in 1 week? ______

This is one unit

of alcohol…

…and each of these is

more than one unit

Questions	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 drinking	1-2	3-4	5-6	7-9	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Now add up your score and write it here:

If you scored 5 or above please fill out the questionnaire on the page 4

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 guild 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	

Now add up your score above and write it here:

Add the score from Page 3 and above together and write here:

Scoring *-*

0-7 Lower Risk

8-15 - Increasing risk

16-19 - Higher Risk

20+ - Possible dependence

OFFICE USE ONLY

Staff Initials

ID Seen

Date Handed in

Last 3 characters of id

Co. Signed

Date Entered on Emis

Opt In/Out Patient Choice Form

For more information on data sharing please see our web site under GDPR and also www.nhsdatasharing.info.

Please tick the following if you wish to **OPT-IN**

Please note that by opting out of the SMS Texting ,EMAIL or Telephone notifications, you will not receive appointment reminders or health information

To receive SMS text reminders for appointments and health promotion information	**YES**	☐	**NO**	☐
To receive Email reminders for appointments and health promotion information	**YES**	☐	**NO**	☐
To receive telephone reminders for appointments and health promotion information	**YES**	☐	**NO**	☐

***IMPORTANT INFORMATION ABOUT YOUR HEALTH RECORD (Please read carefully)**

The NHS shares data from your medical record in a number of ways. You have the right to control how your personal information is used and who has access to it. You can opt out of this data sharing by completing the form below. We will then add relevant coding to your record to stop the extraction and processing.

I agree to the following information to be extracted and uploaded from my GP record for the following purposes:

National Data Opt-Out

This information is used by NHS England and Public Health England to determine future demand on services, or for research into the treatment of conditions. This will also include the National Diabetic Audit and other National Audits that the practice may part in. **(**https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/national-diabetes-audit)

To **Opt Out** of this please visit ***https://www.nhs.uk/your-nhs-data-matters/*** *where you will need to register your preference not to take part.* ***We cannot do this for you.***

The following options are for data sharing related to your direct health care. You are opted in by implied consent unless you let us know. You have the right to change your mind at any time.

The Summary Care Record— Please opt me out of the Summary Care Record **YES** ☐ **NO** ☐
(*If you have selected YES to the above option do not tick the 2 options below)*
I Express consent for medication, allergies and adverse reactions only. **YES** ☐

I Express consent for medication, allergies, adverse reactions and additional information. **YES** ☐

The Summary Care record is a national record which can be accessed by healthcare professionals who may need to treat you in other parts of the country. It contains information on your main diseases, medications ,allergies, immunisations, care plans and significant medical history (past and present) which may be crucial to your care in an emergency situation**.** If you do not want your data to be available to other services on the national spine, please let the practice know and we will ensure you are **Opted out** of this data sharing

The Care and Health Information Exchange, (CHIE) - Please Opt me out of the Hampshire CHIE **YES** ☐ **NO** ☐

CHIE is a Hampshire wide database which healthcare professionals in other practices and the local hospitals can access if they need to treat you. They can ask you to view your practice record, such as when you visit a local Hub – and this may be important to providing you with the correct care. It is not available to health services outside of Hampshire – who would use the Summary Care Record to obtain important information about you.

I understand that I can opt in/out to any or all of these databases at any time in the future by informing the Practice in writing.

Patient Name: ________________________________ Patient Signature: ______________________________

Date: ________________