

Castle Donington Surgery - New Patient Questionnaire – Adult

OFFICE USE ONLY ** ID Seen

Photo ID Seen Type _____

Address ID Seen Type _____

For each new patient registration, please complete this questionnaire and a separate GMS1 form.

Please supply photocopies of TWO forms of identification with your completed forms, a photographic form of ID (such as a PASSPORT or DRIVING LICENCE) and proof of your home address (such as a recent BANK STATEMENT or UTILITY BILL)

If you have newly arrived to this country, please bring your passport to confirm place of origin.

Current details - please complete in BLOCK CAPITALS

TITLE:		FIRST NAME:		SURNAME NAME:	
GENDER:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other:			PREV SURNAME:	
DATE OF BIRTH:			NHS NUMBER:		
Current address and postcode:					
			TELEPHONE NUMBER:		
			WORK NUMBER:		
			MOBILE NUMBER:		
			E-MAIL ADDRESS:		
TOWN & COUNTRY OF BIRTH:			MARITAL STATUS:		
<p>Please tick to consent / dissent to the following forms of contact</p> <p>The practice is developing ways of using text and email, for those patients who consent, instead of paper letters where possible. This is part of our green initiatives to save paper, reduce cost and improve the speed in which we communicate with patients.</p> <ul style="list-style-type: none"> • Text messages are primarily used for sending appointment reminders and confirmations. We do not send personal medical information via text message, unless otherwise agreed with the patient. • Email is used primarily used when a patient requests to be sent copies of information. 					
Email	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mobile text messages	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Answering machine messages	<input type="checkbox"/> Yes <input type="checkbox"/> No				

Previous details – please complete as fully as you can. This helps us to retrieve your medical records

Previous address and postcode:	Previous doctor's name and address:
If applicable, date you first came to live in Britain:	Previous doctor's telephone number:

Next of kin

Full name:		Contact number:	
Their relationship to you: (<i>Spouse, friend etc.</i>)		Address: (<i>If different from above</i>)	

Ethnicity and language

Please choose one that best describes your ethnic group or background							
White British	<input type="checkbox"/>	White Irish	<input type="checkbox"/>	Other White:			
Black Caribbean	<input type="checkbox"/>	Black African	<input type="checkbox"/>	Other Black:			
Asian Indian	<input type="checkbox"/>	Asian Pakistani	<input type="checkbox"/>	Other Asian:			
Mixed White & Black Caribbean	<input type="checkbox"/>	White & African	<input type="checkbox"/>	White & Asian	<input type="checkbox"/>	Other:	<i>Please Specify</i>

First language spoken / understood: (select one)													
English	<input type="checkbox"/>	Spanish	<input type="checkbox"/>	Gujurati	<input type="checkbox"/>	Urdu	<input type="checkbox"/>	Bengali / Sylheti	<input type="checkbox"/>	Punjabi	<input type="checkbox"/>	Ukrainian	<input type="checkbox"/>
Polish	<input type="checkbox"/>	French	<input type="checkbox"/>	Romanian	<input type="checkbox"/>	Hindi	<input type="checkbox"/>	Other: Please Specify					
DO YOU REQUIRE AN INTERPRETER?				Yes <input type="checkbox"/>			No <input type="checkbox"/>						

Military status – Have you ever served in the armed forces or received military status?

If YES, please state in what capacity:				
Address prior to enlistment:			Your service or personnel number:	
			Your enlistment date:	
			Your discharge date:	

Occupation Information

Occupation:		Job role:	
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Health information

Your height:	Feet / inches	cm	Your weight:	Stones / lbs	Kg
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Smoking, alcohol consumption and exercise:							
Are you currently a smoker?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Have you ever been a smoker?		Yes <input type="checkbox"/>	No <input type="checkbox"/>	
If so, how much do you smoke in a day?	Cigarettes		<i>If you are a smoker and want to stop, please ask for information about local smoking cessation services.</i>				
	Cigars						
	Tobacco						
How often do you have a drink that contains alcohol?	N/A <input type="checkbox"/>	Never <input type="checkbox"/>	Monthly or less <input type="checkbox"/>	2-4 times per month <input type="checkbox"/>	2-3 times per week <input type="checkbox"/>	4+ times per week <input type="checkbox"/>	
How many standard alcoholic drinks do you have on a typical day when you are drinking? (one unit = 1 small glass of wine, a single measure of spirits, or ½ a pint of beer)	N/A <input type="checkbox"/>	1-2 <input type="checkbox"/>	3-4 <input type="checkbox"/>	5-6 <input type="checkbox"/>	7-9 <input type="checkbox"/>	10+ <input type="checkbox"/>	
How often do you have 6 or more standard drinks on one occasion?	N/A <input type="checkbox"/>	Never <input type="checkbox"/>	Less than monthly <input type="checkbox"/>	Monthly <input type="checkbox"/>	Weekly <input type="checkbox"/>	Daily or almost daily <input type="checkbox"/>	
Number of times a week you exercise?				Type(s) of exercise:			

Your history

Do you have any current medical problems? If yes, please list:	
What other illnesses have you had and when?	
What operations have you had and when?	
Please list any tablets, medicines or other treatments you are currently taking: (include dose and frequency)	

Are you allergic to any drugs? If yes, please list	
Any other allergies? If yes, please list	

Information and Communication Needs

Do you have any information or communication support needs relating to a disability, impairment or sensory loss? If yes, please specify.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Communication or information method required, i.e. braille; email	

ARE YOU A CARER OR DO YOU HAVE A CARER?

Carers are people who, without payment, provide help and support to a family member, friend or neighbour who cannot manage on their own due to physical or mental illness, disability, substance misuse or frailty brought on by old age.

Support for carers is available. Please ask at reception for details or tick here to be contacted

Please enter the details of the **person you care for**

Full name:		Contact number:	
Their relationship to you: (<i>Spouse, friend etc.</i>)			
Address: (<i>If different from yours</i>)			

Please enter the details of the person **who cares for you**

Full name:		Contact number:	
Their relationship to you: (<i>Spouse, friend etc.</i>)			
Address: (<i>If different from yours</i>)			

Please sign and date here if you consent for us to discuss information about you and your health with your carer

Signature..... Date

Living Wills and Power of Attorney

DO YOU HAVE A "Living Will"? (A statement explaining what medical treatment you would not want in the future.)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<i>If "Yes", can you please bring a written copy of it to your records</i>
HAVE YOU ASSIGNED A POWER OF ATTORNEY? Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If "Yes", please state their name / address / phone number & bring in a copy your records

Data Sharing and YOUR Medical Records “Your Data Matters”

Your medical records can be made visible to other organisations that provide healthcare services to you.

For more information you can visit <https://www.castledoningtonsurgery.co.uk/gdpr-and-privacy> or ask for an information leaflet from reception.

Summary Care Records

Summary Care Records (SCR) are electronic records of important patient information, created from GP medical records. A Summary Care Record will contain important information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines that you have had. Giving healthcare staff access to this vital information can help them treat you more quickly and effectively in an emergency or when your GP practice is closed.

You can choose to have an Enhanced Summary Care Record which contains all of the above as well as relevant medical history, immunisations and long term medical conditions.

Core Summary Record <i>Medication, bad reactions and allergies.</i>	<input type="checkbox"/>
Enhanced Summary Record <i>Medication, bad reactions/allergies and additional information, including relevant medical history, immunisations and long term medical conditions.</i>	<input type="checkbox"/>
Decline <i>If you do not wish to have a Summary Care Record.</i>	<input type="checkbox"/>

Blood and organ donation preferences

We can no longer process your blood or organ donation preference directly through your GP practice.

If you wish to register your preferences, please do this by the organ donation online registration websites or directly by phone.

- To register for blood donation visit <https://www.blood.co.uk>
- To register for organ donation visit <https://www.organdonation.nhs.uk>
- To register for Blood or Organ donation by phone call: 0300 123 23 23

Patient Signature

In compliance with the changes to the Data Protection Act (GDPR), by signing and completing your registration with us, you are agreeing to the terms explained within our Privacy Notice. Copies are available on request and are published on our practice website.

Patient Signature:		Signature on behalf of Patient:	
Date:			

Thank you for taking the time to complete this form

For more information about the services we offer, please refer to your patient leaflet or see our website: www.castledoningtonsurgery.co.uk