***Dr Kumar & Dr Sinha***

**NEW PATIENT QUESTIONNAIRE**

Please complete this questionnaire as fully as possible. The information will help the health care team to make an initial assessment of your health which will help in your future treatment. It often takes us several months to obtain your medical notes from your previous doctor and the more information we have, the better we can help you.

The completed form must be returned to reception with your other registrations forms. This information will be held in your personal health record which, like all NHS records, remains confidential.

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| **PERSONAL DETAILS** |
| **Surname:** | **First name(s):** |
| **Previous surname(s):** | **Sex:** Male/female **Title:** Mr/Mrs/Miss/Ms/Dr/Other |
| **Date of birth:** | **Occupation:** |
| **Home address:** |
| **Home tel:** | **Mobile tel:** |
| **Work tel:** | **Email:** |
| *We may occasionally want to contact you to remind you of an appointment.* Do you consent to us contacting you by SMS text message? Yes/No Do you consent to us contacting you by email? Yes/NoDo you wish to register for on-line services? Yes/No | **ARE YOU A CARER?**Do you look after someone? Yes/NoIf Yes do you wish to be referred for a carers assessment? Yes/NoThere is free support and advice for you please ask reception or go on line:[www.carersuk.org](http://www.carersuk.org)  |
| **Have you ever served in the British Armed Forces?** |  |
| **CONTACT DETAILS OF YOUR CARER (IF APPLICABLE)**  |
|  |
| **Name: Relationship:** |
| **Contact number(s):**  |
| **Next of Kin** |
| **Name: Relationship:****Contact number(s):** |
| **School Age Children** |
| **Name of School:** | **Address:** |

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| **Summary Care Record** |
|  The Summary Care Record (SCR) is an electronic copy of key information held in your GP record. It provides authorised healthcare staff with faster, secure access to essential information about you - when you need unplanned care or when your GP practice is closed. These means if you ever have an accident or become ill or need urgent care, treatment or advice away from your regular GP the clinician treating you will have immediate access to your Summary Care Record. The availability of Summary Care Records will improve the safety and quality of your care.Further information can be found <http://systems.hscic.gov.uk/scr/patients/what> or ASK RECEPTION**Do you have a summary care record? Yes / No****Do you want a summary care record? Yes / No** |

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| **HEALTH INFORMATION** |
| **Height:** | **Weight:** |
| **Do you smoke?** Yes/noCigarettes/cigars/pipe/roll-ups | **If yes, how many per day?** |
| **Have you ever smoked?** Yes/no | **If you have stopped smoking, give approximate date you stopped:** |
| *We strongly recommend that patients do not smoke. If you would like advice or help to give up smoking please speak to either your GP, nurse or enquire at reception for details of our smoking cessation services.* |
| **Do you have any allergies?** animals/pollen/nuts/medication/other (please specify) |
| **Have you ever suffered from a bad reaction to any medication?** Yes/noIf yes, please give details: |
| **What medication do you currently take?** (include all prescription and over the counter): |
| **What regular exercise do you take?** |
| **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 you are drinking?**1 - 2 3 - 4 5 - 6 7 - 8 10+ |
| **How often do you have 6 or more standard drinks on one occasion?**Never Less than monthly Monthly Weekly Daily or almost daily |

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| **PERSONAL MEDICAL HISTORY** |
| **Please give details of any serious illness, accident, ongoing condition, operations or special needs including dates:** |
| **Sexual Health** Tick Box Sexually active   Not sexually active Never been sexually active |
| **As part of our commitment to reducing rates of STI’s we now offer routine screening as part of every new patient check for those aged 16 and over.**Urine screen for chlamydia Yes/No |
| **Do you feel that you are having problems with your memory?** *Yes / No**If you have concerned about problems with your memory and have marked yes to the question above the practice nurses will speak with you during your new patient health check.* |
| **For Women** | **For Men** |
| **Do you use contraception? Yes / No** ***If Yes Please state which type.*****Have you had any children? Yes / No** ***if yes ages\_\_\_\_\_\_\_\_\_\_\_*****Have you had a miscarriage? Yes/ No** ***If yes Date*** *\_\_\_\_\_\_\_\_\_\_\_\_\_***Hysterectomy Yes / No** ***If yes Date:*  \_\_\_\_\_\_\_\_\_\_\_\_\_****Please give the date of your last cervical Smear:** | **Have you had a Vasectomy? Yes / No****(If yes) Date: ----------------** |
| **Family Medical History** |
| **Have any close relatives (parents, brothers, sisters or children) suffered from any of the following or died before the age of 65? Please specify the disease and their relationship to you.*****Heart disease (heart attacks/angina)?******Stroke?******Cancer?******Asthma?******COPD?******High Blood Pressure?******Epilespy?******Diabetes?******Thyroid disease?******Other?*** |

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| **Ethnic Background** |
| **Ethnic Group** | **Tick Here** |
| **A: White*** British
 |  |
| * Irish
 |  |
| * Any other white background (please write in line below)
 |  |
| **B: Mixed** |  |
| * White and Black Caribbean
 |  |
| * White and Black African
 |  |
| * White and Asian
 |  |
| * Any other mixed background (please write in line below)
 |  |
| **C: Asian or Asian British** |  |
| * Indian
 |  |
| * Pakistani
 |  |
| * Bangladeshi
 |  |
| * Any other Asian background (please write in line below)
 |  |
| **D: Black or Black British** |  |
| * Caribbean
 |  |
| * African
 |  |
| * Any other Black background (please write in line below)
 |  |
| **E: Chinese or other ethnic group** |  |
| * Chinese
 |  |
| * Any other (please write in line below)
 |  |
| **Not stated/declined*** Declined: patient chooses not to supply this information
 |  |
| Language  |
| Are you an English speaker? Yes /No *If No Please tick the appropriate box to indicate your main language spoken* |
| Arabic |  | Hakka  |  | Somali |  | Punjabi |  |
| Bengali |  | Hindi |  | Spanish |  | British Sign Language |  |
| Cantonese |  | Korean |  | Tamil |  | Any other language (specify) |  |
| Farsi |  | Mandarin |  | Turkish |  |
| French |  | Patois/Creole |  | Urdu |  |
| Gaelic |  | Polish |  | Vietnamese |  |
| Gujarati |  | Portuguese |  | Welsh |  |

**Please let us know which Pharmacy you would like your prescriptions to be automatically sent to:**

**PHARMACY NAME:**

**………………………………………………………………………………………………**

*Section below for office use* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient informed of accountable GP: Yes No

By: Please sign/initial \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_