NEW PATIENT QUESTIONNAIRE (16 and over)

Lytham Road Surgery

Please complete as many questions as you can. The information will help the practice to provide better medical care for you.

Surname: ……. First Name: …… Maiden name: ……..

Gender: Male/Female Date of Birth: ……

Home Tel No: …… Mobile No: ……

Email Address: ……

Do you consent to being contacted via: Telephone ☐ Mobile ☐ Email ☐

Marital Status:Single/Married/Separated/Divorced/Widowed

Occupation: ……

Height: ……m/ft Weight: ……kg/st

Ethnicity (Please circle) White/Black:- Caribbean/African

Asian:- Indian/Pakistani/Bangladeshi/Chinese/Other……..

First Language: …… Interpreter required? Yes/No

Next of Kin

Name: …….. Contact No: ……

Relationship: ……

1. Do you live alone Yes ☐ No ☐
2. Do you have a carer? Yes ☐ No ☐

Name of Carer: …… Relationship: …… Tel. No: ……

Do you consent to us contacting your carer? Yes ☐ No ☐

3. Are you a carer for a relative or friend? Yes ☐ No ☐
4. Do you have any dependents? Yes ☐ No ☐
5. Have you ever or are you currently serving in the Armed Forces? Yes ☐ No ☐

   If Yes are you currently, serving as a Reservist ☐ serving in British Armed Forces ☐ Veteran ☐
6. Are you dependant on a current serving member of the British Armed Forces? Yes ☐ No ☐
7. Are you member of a Military Family? Yes ☐ No ☐

CONTINUE TO PAGE 2

Personal Medical History – what major illnesses have you had in the past?

Please list serious or chronic illnesses, operations, or disabilities:		
Year:	**Have you ever needed treatment for:**	Please **ring** as appropriate
	HIV	Yes No
	Hepatitis	Yes No
	Epilepsy / fits	Yes No
	Blindness / Glaucoma	Yes No
	Blood Pressure (hypertension)	Yes No
	Diabetes	Yes No
	Stroke or TIA	Yes No
	Heart Attacks	Yes No
	Asthma	Yes No
	Cancer	Yes No
	Depression	Yes No
	Mental Health Problem	Yes No
	Kidney Disease	Yes No
	Dementia	Yes No
	COPD (Bronchitis or Emphysema)	Yes No
	Thyroid Problem	Yes No
	History of Fractures	Yes No
	Osteoporosis	Yes No
	Rheumatoid Arthritis	Yes No
	Have you had any operations or procedures? **If Yes please state what & when:**	Yes No

6. **Medical History Of immediate Family** – **(parents, brothers, sisters, uncles, aunts, grandparents)**

Please state below

Has any close relative suffered from the following:		**Age when diagnosed**	**Relationship to you**
Blood Pressure (hypertension)	Yes ☐ No ☐		
Heart Attack or Angina	Yes ☐ No ☐		
Diabetes	Yes ☐ No ☐		
Stroke or TIA	Yes ☐ No ☐		
Cancer	Yes ☐ No ☐		

CONTINUE TO PAGE 3

7. **Disability, Age Related Problems or Special Needs**

Do you have any problems with:-	
Vision	Yes ☐ No ☐
Speech	Yes ☐ No ☐
Mobility	Yes ☐ No ☐
Hearing	Yes ☐ No ☐
Learning Difficulties	Yes ☐ No ☐

Lifestyle

8. Do you have a special diet? Yes ☐ No ☐ If yes, what?.....

9. Do you smoke? Yes ☐ No ☐

Cigarettes: …… per day Cigars: …… per day Pipe: …... ozs per week Tobacco: ……. ozs per week

Do you use Electronic Cigarettes? Yes ☐ No ☐

Have you ever smoked? Yes ☐ No ☐ If yes, when did you stop? ……

If you do smoke, do you wish to discuss stopping smoking? Yes ☐ No ☐

(If Yes then please contact Quit Squad – Tel: 01772 644 474 or www.quitsquad.nhs.uk – they will offer support to help you quit.

10. **Do you drink alcohol?** Yes ☐ No ☐ **If yes, how much?: …….. units per week.**
Please complete the three questions below:

Questions	0	1	2	3	4	Your Score
How often do you have a drink that contains alcohol	Never	Monthly of 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 -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	

11. Do you undertake any sport or exercise? Yes ☐ No ☐

Daily? 2-3 times a week? Weekly? Occasionally?

What exercise do you do? ……

12. Have you ever had your Blood Pressure checked? Yes ☐ No ☐ If yes, When? .....

Has your Blood Pressure ever been high? Yes ☐ No ☐

13.**Please list your present medication**

Please provide a print out of your medication if you need it on a regular basis.

CONTINUE TO PAGE 4

14. **Please list any allergies to medicine**

15. **Immunisation: Please give details:** **When was your last:-**

Diptheria/Tetanus/Polio: ……..

Influenza: ……..

Pneumonia: ……..

Travel Immunisations? ……

SIGN UP FOR TEXT MESSAGING FACILITY

There is a new facility available to send appointment reminders both from the surgery and hospital appointments. It can also be used to send information about any tests you have done at the surgery.

If you would like to sign up for this service, please fill in the details below. NB: In line with Data protection we will not share your information or use it for any other purpose other than what is stated above.

Mobile Number …… Signature ……

SIGN UP FOR EMAIL COMMUNICATION

We would also like to develop a system in future of sending letters/communications to you by email. If you are happy for this to happen, please complete below.

I……..agree that the Practice can send letters to me by email and I understand that such communications could contain confidential medical information.

Email address:…… Signature……

Summary Care Record Sharing

Do you **object to** your summary care record being available when you access NHS care outside of your GP Practice (for example NHS Out of Hours Services or Accident & Emergency)? Yes ☐ No ☐

Thank you for your co-operation. If you have any other specific concerns about your medical care that you would like us to be aware of, please do book an appointment with the practice.

Today's Date …… Signature ……

WOMEN ONLY

Have you / do you attend a family planning clinic? Yes ☐ No ☐

Do you take a contraceptive pill/injection? Yes ☐ No ☐ Which one? ……

How long have you been taking the pill/injection? ……

Are you fitted with a coil? Yes ☐ No ☐ When was it fitted? ……..

Have you ever been fitted with an implant? Yes ☐ No ☐ When was it fitted? ……

Have you ever had a cervical smear? Yes ☐ No ☐ If Yes, date of last one: ……

Result of cervical smear: ……..

Have you ever been pregnant? Yes ☐ No ☐ If yes: a) How many children do you have? ……..

b) Have you had any miscarriages? Yes ☐ No ☐

Have you been immunised against Rubella? Yes ☐ No ☐