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:…….

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 any general surgery communication including information regarding 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……

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

Occupation: ……

Height: ……m/ft Weight: ……kg/st

Ethnicity (Please circle) British/Mixed British, Black African, White African, Indian/British Indian, Pakistani/ British Pakistani, Other Asian, Polish, Romanian, Chinese,
Other (please specify) …….

First Language: …… Interpreter required? Yes/No

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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 ☐

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
	High Blood Pressure	Yes No
	Low Blood Pressure	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

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	Have you had any operations or procedures? **If Yes, please state what & when:**	Yes No

8. **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 ☐		
If answered yes to Cancer, please advise what type of cancer?			

9. **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 ☐

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Lifestyle

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

11. 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.

12. **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	

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

14. **Immunisation: Please give details:** **When was your last:**

Diphtheria/Tetanus/Polio: ……

Influenza: ……

Pneumonia: ……

Travel Immunisations? ……

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Information for new patients: about your Summary Care Record

Dear patient,

If you are registered with a GP practice in England, you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.
Information about your healthcare may not be routinely shared across different healthcare organisations and systems. You may need to be treated by health and care professionals who do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs.
Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

You have a choice

You have the choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care.
Your options are outlined below; please indicate your choice on the form overleaf.

- **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies for adverse reactions only.

- **Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies for adverse reactions and further medical information that includes: your illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.

- **Express dissent for Summary Care Record (opt out).** Select this option, if you **DO NOT** want any information shared with other healthcare professionals involved in your care.

If you chose not to complete this consent form, a core Summary Care Record (SCR) **will** be created for you, which will contain only medications, allergies and adverse reactions.

Once you have completed the consent form, please return it to your GP practice.

You are free to change your decision at any time by informing your GP practice.

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Summary Care Record patient consent form

Having read the above information regarding your choices, please choose **one** of the options below and return the completed form to your GP practice:

Yes – I would like a Summary Care Record

☐ Express consent for medication, allergies and adverse reactions only.

or

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

No – I would not like a Summary Care Record

☐ Express dissent for Summary Care Record (opt out).

Name of patient: ……..….....

Date of birth: …… Patient's postcode: ……

Surgery name: …… Surgery location (Town): …….....

NHS number (if known): ……..…….....

Signature: …… Date: ……

If you are filling out this form on behalf of another person, please ensure that you fill out their details above; you sign the form above and provide your details below:

Name: …….....

Please circle one:

Parent	Legal Guardian	Lasting power of attorney for health and welfare

For more information, please visit https://www.digital.nhs.uk/summary-care-records/patients, call NHS Digital on 0300 303 5678 or speak to your GP Practice.

For GP practice use only

To update the patient's consent status, use the SCR consent preference dialogue box and select the relevant option or add the appropriate read code from the box options below.

Summary Care record consent preference	Read 2	CTV3
The patient wants a core Summary Care Record (express consent for medication, allergies and adverse reactions only)	9Ndm.	XaXbY
The patients wants a Summary Care Record with core and additional information (express consent for medication, allergies, adverse reactions and additional information)	9Ndn.	XaXbZ
The patient does not want to have a Summary Care record (express dissent for Summary Care Record- optout)	9Ndo.	XaXj6