Summerfield GP and Urgent Care Centre

New Patient Questionnaire

Thank you for completing this questionnaire the information is vital to ensure we understand your medical needs.

Patient details

Surname	First name/s
Maiden name or previous name	Title (Mr, Mrs, Miss, Ms)
Date of birth	Work telephone
Home telephone (01603)	Mobile no
We will in the future be able to send text messages (appointment reminders or information). Would you be happy to receive them? (please tick) Yes □ No □	
Occupation	
Does your occupation involve you working with poultry? Yes □ No □	
Email address:	
Ethnic group	First language

Next of kin

Name	
Address	
Telephone contact	
Relationship	

Carer

Are you a carer?	Yes □ No □

Please ask the receptionist for one of our carer packs.

Do you have a carer?	Yes □ No □

If yes please note below their name and contact telephone number

.....

.....

.....

Height :.....

Weight:.....

significant Illnesses/conditions
(please tick relevant boxes and give date first diagnosed)

Insulin treated Diabetes Date		Tablet treated Diabetes Date		Diet controlled Diabetes Date	
High blood pressure Date		Heart Disease Date		Asthma Date	
Cancer Date		Epilepsy Date		Thyroid problems Date	
Stroke Date		Other type of chest problem Date Type		COPD Date	
Angina Date		Heart Attack Date		Chronic kidney disease Stage Date	
Other Date		Other Date		Other Date	

Ongoing Investigations or tests (blood, urine, x-rays, MRI or ultrasound)

Test	**When completed**	**Result if known**	**Treatment plan if known**

Operations
Have you had any operations?

Operations	**Date**

Admissions to hospital
Have you been admitted to hospital and for what reason?

Reason for admission to hospital	**Date**

Family Medical History
Has any of your family - mother/father/brothers/sisters suffered from any of the following - please state which relative.
Please tick relevant boxes

Heart disease		Stroke		High cholesterol	
Diabetes		Hypertension		Asthma	
Bowel cancer		Breast cancer		Cancer	
Glaucoma		Other		Other	

Drugs and Medicines
Please tick relevant boxes

Are you being prescribed medication on a repeat basis?	Yes □ No □
Please list all the medication that you are currently taking (please attach your last repeat slip if possible):	

Are you on any medication supplied by the Hospital	Yes □ No □
Please list below	

When was your last medication review?	Date

(this is normally completed annually)	
BP check	Date Result if known
Cholesterol check	Date Result if known

Are you allergic to medications? If yes please list below:	Yes □ No □

Disability Information

Please tick relevant boxes

Partially sighted		Blind		Hearing impaired	
Deaf		Speech defect		Dyslexia	
Learning disability		Mental illness		Mobility problem (please explain)	

Lifestyle

Please tick relevant boxes;

How active are you?

Very Active Yes □ No □	Moderately Active Yes □ No □
Some Exercise Taken….. Yes □ No □	No Exercise Taken Yes □ No □

Smoking

Do you smoke? Yes □ No □	If yes number per day ……..
Are you an ex smoker? Yes □ No □	Have you never smoked? Yes □ No □

We strongly recommend that patients do not smoke. If you would like advice or help to stop smoking please enquire at reception for details of our smoking cessation services.

Drinking alcohol

Bottle of wine 7 units, Pint of cider 2.3 units, pint of beer 2 units, quarter bottle of wine 1.8 units, alcopop 1.2 units, spirits 1.1, half pint of beer 1 unit & small glass of wine 1 unit.

Questions	**Scoring system**					**Your score**
	0	**1**	**2**	**3**	**4**	
How often do you drink alcohol?	Never □	Monthly or less □	2-4 times per month □	2-3 times per week □	4+ times per week □	
How many units of alcohol do you drink 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 units (standard drinks) if female, or 8 or more if male, on one occasion?	Never □	Less than monthly □	Monthly □	Weekly □	Daily/ almost daily □	

Scoring
A total of 5+ increasing or higher risk of drinking.

Exercise
Please tick

Very active		Moderate		Gentle		Inactive	

Diet
Please tick

Good		Moderate		Poor		Vegetarian		Vegan	

About you

Height		Weight	

Do you have non drug allergies	Yes □ No □

If yes please tick below

Nuts		Insect bite		Pollen		Latex		Other	

Is this allergy
Please tick

Mild		Moderate		Severe		Very Severe	

Over the counter medication

Do you take Aspirin regularly, which you buy over the counter?	Yes □ No □
Do you take any other over the counter medications regularly (please list below)	Yes □ No □

Adults

Have you had a course of tetanus injections or a tetanus booster in the last 10 years?	Yes □ No □ Date

Summary Care Record

The summary care record is an electronic record which will give healthcare staff faster, easier access to essential information about you, to help provide you with safe treatment when you need care in an emergency or when a GP practice is closed.

Have you previously opted out of the summary care record?	Yes □ No □
Do you wish to opt out of the summary care record?	Yes □ No □

Women only

Form of contraception used

Please tick

Pill		Coil (IUD)		Condom		Diaphragm (cap)		Other	

Do you have children? If so please give dates and how delivered (eg normal birth, caesarean etc)

Date	Details

Smear Test (if aged between 25 and 64 years)

Date of last smear:	Result: Normal □ Abnormal □

I declare to the best of my knowledge and belief that this information is correct and true.

Signature……Dated……

Print Name……

Service Name (please tick & initial)

GSM1		**Patient Questionnaire**	
Proof of ID		**Proof of residency**	
In practice area		**Access to online appts (password)**	
New Patient check with GP - on meds (anti depressants, controlled drugs & epileptics)		**New patient check with Nurse or NP** – (Asthma, COPD, diabetic, Hypothryoidism (Hyper), CHD, IHD, Epilepsy, Hypertension,	
New patient check with Nurse / NP – contraception (on pill)		**NHS Healthcheck** (CVD check) aged 40 - 74	
New patient check - Patient is a carer		Given carer pack	