ST HELENS MEDICAL CENTRE

NEW PATIENT QUESTIONNAIRE
17years and over

New Patient Registration Checklist

- a completed NHS Family Doctor Services Registration GMS1 Form
- a completed New Patient Questionnaire
- repeat slip if you are on repeat medication
- proof of identity: medical card, passport or driving licence

We are pleased to welcome you to our Practice. As it is important that we have significant medical information available about you should you need to consult a clinician prior to the transfer of your medical record, please answer the following questions about your health:

Title: **Forename(s):**	**Surname:**
Address:	
Telephone:	**Mobile:**
Email Address: We have **online services** available through our website: **www.sthelensmedicalcentre.org**	
Occupation:	
Date of birth:	**Marital Status:**
Next of kin:	**Next of kin contact tel:**

Do you have a carer Y N **If yes are you happy for us to refer you to Community Care outreach team? Y N**	**Are you a carer Y N** **If yes are you happy for us to refer you to Community Care outreach team? Y N**
Name and address of carer:	
Tel:	

Do you have Asthma? Y or N

Smoker Y/N Non Smoker Y/N Ex-Smoker Y/N date stopped …….

Diet: Good Y/N Moderate Y/N Poor Y/N

Exercise: Inactive Y/N Gentle Y/N Moderate Y/N Vigerous Y/N

Drug Allergy: **Non-Drug Allergy:**

(1 unit = one small glass of wine, one measure of spirit or half pint of beer)
(Safe limits = male: 21 units, female: 14 units**)**

Questions	0	1	2	3	4	Your Score
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	

Scoring: a total of 5+ indicates hazardous or harmful drinking. You may be invited to attend the surgery for further alcohol advice.

Have you been vaccinated against pneumonia? **Yes** ☐ **No** ☐	**If yes, please give date:**
Have you ever had a seasonal flu jab? **Yes** ☐ **No** ☐	
Have you ever had a Shingles Vaccination **Yes** ☐ **No** ☐ **(Patients aged 70-79 only)**	

WOMEN ONLY

Is there a family history of breast cancer? Yes ☐ No ☐

If so, relationship and age diagnosed:

If you have breast cancer, date diagnosed:

If you are 50+, date of last mammogram:

If you are on oral contraception or HRT, please indicate name:

SMEAR Date of last cervical Smear:

PREGNANCIES

Date of Birth	Complications	Sex (M or F)

I understand and accept that all data held about me is protected and not automatically divulged to third parties except other health care workers requiring my medical details as a necessary part of an openly agreed referral to other medical teams, i.e. the hospital, or members of social services needing to know selected parts of my record in order to do their job on my behalf.

If you need to know more about how we use your healthcare information, please visit our website www.sthelensmedicalcentre.org or request our leaflet, “How we use your information.”

Care Data: Opt-Out Form

Shared Health Records on the Isle of Wight

Please complete this form if you **DO NOT** want a summary of your healthcare record held by your GP to be shared with other health services on the Isle of Wight. Please print your details.

To GP Surgery
I the undersigned DO NOT want my GP records to be shared with the Isle of Wight Emergency Healthcare Providers.

Surname:	**Forename(s):**
Address: **Post code:**	**Date of Birth:**
Signature:	**Date:**

If you are signing on behalf of someone for whom you are a parent/guardian or carer:

Name:	**Capacity/relationship:**
Signature:	**Telephone number:**

Shared Health Records Nationally

To GP Surgery
I the undersigned DO NOT want my personal confidential data from hospitals and other care providers to be released by the Health & Social Information Centre (HSCIC) for the care.data programme.

Surname:	**Forename(s):**
Address: **Post code:**	**Date of Birth:**
Signature:	**Date:**

If you are signing on behalf of someone for whom you are a guardian or carer:

Name:	**Capacity/relationship:**
Signature:	**Telephone number:**
Completed by (staff member):	**Date:**

Leaving Messages

In accordance with the **Data Protection Act** the Practice needs consent from any patient that has an answer phone and is happy for us to leave a message. If we do not have consent, we will be unable to leave a message on an answer phone or with a third party.

Please complete the appropriate field(s):

☐ I give consent for the Practice to leave messages on my answer phone.
Telephone number: and / or:

☐ I DO NOT give consent for the Practice to leave messages on the answer phone.

☐ I DO NOT give consent for the Practice to leave messages with a third party.

☐ I give consent for the Practice to leave a message about any aspect of my medical treatment with:

Name: **Relationship:**
Name: **Relationship:**

This consent is to remain in force until further notice of cancellation by me.

Signed: **Print full name:**

PATIENTS OVER 75years ONLY

RISK FACTORS	Lives alone		Has home help		Warden Assisted		Has meals on wheels		Shopping
OPTICIAN LAST SEEN									
PREVIOUS OCCUPATION									
VISION	Satisfactory		Treatment being reviewed		Wears Glasses		Registered partially sighted		Registered blind
HEARING	Satisfactory		Treatment being reviewed		Wears hearing aid				
MOBILITY LEVEL	Fully Mobile		Mobile outside with aid		Mobile in home with aid		Housebound		Wheelchair
MEMORY	Satisfactory		Problem						
MENTAL EMOTIONAL STATE	Satisfactory		Problem						
PHYSICAL HEALTH	Satisfactory		Problem						
OVER THE COUNTER DRUG USE	*ie: Aspirin* Yes/No Other Drug……								
CONTINENCE – URINARY									
CONTINENCE – BOWEL									