Dr DP Diggle and Dr RE Phillips

New Patient Questionnaire

Please complete this questionnaire to ensure we have the most up to date and accurate information. The information you provide us with on this form will be reviewed in more detail in your New Patient Health Check appointment. This form must be returned to reception upon registration.

Section 1 - Personal Details

Title	**Mr/Mrs/Miss/Ms**	**Date of Birth**	
Forename		**NHS Number**	
Surname		**Sex**	
Current Address	**Postcode:**		
Home Tel. No.		**Mobile Tel. No.**	
Email			
Occupation			
Ethnicity			
First Language:	**English**	**Other:**	

Do you consider yourself to have a disability?			**Yes**	**No**
Details of Impairment	**Physical**	**Learning Disability/Difficulty**	**Other:**	
	Sensory	**Mental Health Condition**		

Do you need any written communication support?	**Large Print**	**Email/SMS**	**Easy Read**	
Do you need any verbal/Face to Face communication support?	**BSL Interpreter**	**Foreign Language Interpreter**	**Hearing Loop**	**Non-Verbal Communication**
Other communication support needs				

Please Note: Some translators must be booked in advance so can only be used for clinical appointments.
The information provided here is to ensure we can communicate effectively with our patients. In 2016/17 we will be increasing the practices' ability to support specific communication requests in line with the new Accessible Information Standard.

Are you a carer?	**Yes**	**No**	**Is someone a carer for you?**	**Yes**	**No**

Please use an additional sheet of paper if you need to provide more information.

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Section 2 – Health Information

Do you drink any alcohol	Yes	No	Approximately how many units per week?	

How often do you drink?	Never	Monthly	2 – 4 times a month	2 – 4 times a week	5 times a week or more

Are you a smoker?	Yes	No	Previously	Date Stopped:	

How many cigarettes per day?		Would you like support and information on quitting?	Yes	No

Do you have a drug addiction?	Yes	No	Details:	

Section 3 – Medical History

Are you currently under any hospital care?		Yes	No
Hospital Name	Name of speciality/Department	Details	

Repeat Medications

Are you on any repeat medication?			Yes	No
Do you have a repeat prescription slip from your previous GP?			Yes	No
If <u>Yes</u> please hand it to reception when you return this form. If <u>No</u> please list the medication below. You will need to see a GP before we can prescribe any medication.				
Name of Drug	Dose & Frequency	Reason for use		

Allergies

Do you have any known allergies?		Yes	No
Allergic to:	Reaction		

Please use an additional sheet of paper if you need to provide more information.

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Do you have, or have you had any health problems, operations or long term conditions?			
	√	Details	Date
Asthma			
Cancer			
COPD			
Chronic Kidney Disease			
Diabetes			
Epilepsy			
Heart Attack/Disease			
High blood pressure			
High Cholesterol			
Osteoporosis			
Stroke			
Mental health problems			
Under/Over active thyroid			
Circulation problems			
Other serious illnesses			
Any operations			

CHILDREN ONLY	Please list all vaccinations								
	Vaccination		√	Date	Vaccination		√	Date
	Diphtheria/Tetanus/ Whooping Cough/Polio	1			Meningitis C	1		
		2				2		
		3				3		
	Pre-school				Booster			
	Pneumococcal	1			Hib	1		
		2				2		
		3				3		
	Measles/Mumps/ Rubella (MMR)	1			Booster			
		2			HPV	1		
	Rubella					2		
	BCG					3		
	Teenage booster Diphtheria/Tetanus/Polio							
	Other:							

Please use an additional sheet of paper if you need to provide more information.

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ANY ADULT VACCINATIONS			
Name	**Date**	**Name**	**Date**

FEMALES ONLY							
	What is your current method of birth control?	**Hysterectomy**	**Contraceptive Pill**	**Condom**	**Coil**	**Partner had vasectomy**	
		Sterilisation	**Injection**	**Implant**	**None**		
	Are you pregnant?	**Yes**		**No**			
	Please list previous pregnancies	**Date**	**Delivery method**				

Section 4 – Family Medical History

Have any of your immediate relatives (brothers/sisters/parents) had any of the following;				
	√	**Details**	**Date**	**Relationship**
Heart attack or angina before 60				
Heart attack or angina over 60				
Asthma				
Diabetes				
Stroke				
Cancer				
Any inherited diseases				

Thank you for completing this questionnaire. Please return to reception with your other registration forms and **book a New Patient Health Check Appointment.**

You will also need to book an appointment with a GP if; *(please tick if required)*

You are taking repeat medication		You are currently under hospital care	

Do you consent to the practice sending SMS (text messages) to your mobile number to remind you of appointments and also important communications?

Mobile Number:		Yes		No	

Please use an additional sheet of paper if you need to provide more information.