Cutlers Hill Surgery

NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE

To the Patient:

To register with the Practice please complete this questionnaire as fully as possible. The information will help the doctor to make an initial assessment of your health which will help in your future treatment.

Surname: …….. Forename(s): ……

Date of Birth: …….. Marital status: ……

Address:
……

…… Postcode: ……

Special instructions for entry (i.e. keycode) if a home visit is required:…….

……

Home tel: …… Mobile: ……

Occupation:
……

Weight (approx): …….. Height: ……

Next of Kin: ……Relationship:……

Next of Kin Contact Details:
……

Date of completion of this form:
……

Would you like to use our online services?
Book/cancel appointments and order repeat medication Yes/No

If **yes** please bring in up to date photo ID e.g. Passport or Driving Licence

SMOKING

Do you smoke? Yes / No

If Yes, how many:
Cigarettes per day …….. Cigars per day……. Ounces of tobacco per day ……..
How old were you when you started smoking? ……..

If No have you ever smoked? Yes/No

EX-SMOKERS
How old were you when you stopped smoking? ……

PASSIVE SMOKING
Are you exposed to smoke at work? Yes / No At home? Yes / No

ALCOHOL

Guide to alcohol use

Pint of Regular Beer/Lager/Cider = 2 units
Alcopop or Can of Lager = 1.5 units
Glass of Wine (175ml) = 2 units
Single measure of Spirits = 1 unit
Bottle of Wine = 9 units

QUESTIONS	Please circle below the answers that apply to yourself				
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
How often in the last year have you found you were not able to stop drinking once you had started?	Never	less than monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Have you or someone else			Yes, but		Yes

EXERCISE

Do you take regular exercise? Yes / No

If yes, what sort of exercise?
……
How many times per week?
……..

FAMILY HISTORY

Is there any of the following in your family (*father, mother, brother, sister etc.)* before age of 65?

Heart Disease (heart attacks, angina) Yes / No Which family member? …….
Stroke? Yes / No Which family member?
…….
Cancer? Yes / No Which family member?
…….
Site of cancer?
……
Diabetes? Yes/No Which family member?

MEDICAL HISTORY

Do you suffer from or have you had any of the following (*please circle)* and do you know the <u>onset date</u>?

Asthma COPD Angina Diabetes Epilepsy Depression

Heart Problems High Blood Pressure Stroke Dementia

Accessible information standard
Do you have any information and/or communication needs if you do please indicate below?

.....

.....

ALLERGIES

Are you allergic to any substances or foods? Yes / No

If yes, please give details:
.....
.....

.....
.....

CARERS

Are you a Carer? Yes / No
Do you have a Carer? Yes / No

ETHNICITY (*please tick appropriate box)*

White British ☐ Black/Black British ☐ Asian/Asian British ☐

Chinese ☐ Other ethnic group please state what……

What is your first spoken language?
.....

Patient Participation Group – would you like to join our group

Yes/No

Summary Care Record – Have you opted NOT to have a Summary Care Record?
(A centrally held health care record available to any health care professionals wherever you are)

I have opted out: ☐ But would like to opt in: ☐

I would like to opt out: ☐

Prevent PCD (patient care data) leaving the GP practice - where a patient objects to PCD leaving the GP practice, (dissent from secondary use of GP patient identifiable Date)

I would like to opt out : ☐

Prevent PCD (patient care data) leaving HSCIC – Where a patient wishes to prevent PCD gathered from any health and social care setting from leaving the HSCIC (Dissent from disclosing of personal confidential data by Health and Social Care Information Centre)

I would like to opt out : ☐

Signature:……Date:…… ……

Print name:……On behalf of:……

(Please note that unless you sign this document we will not be able to process any changes to your summary care record)

Thank you for completing this questionnaire. It is recommended that all new patients make an appointment with a Health Care Assistant or GP for an initial assessment.

****Please Bring 2 forms of ID – Photo ID and a utility bill with your name and address on****