****

**41 BROOMWOOD ROAD, ST PAULS CRAY, ORPINGTON, KENT. BR5 2JP**

**Tel: 01689 832454 Website:** [**www.thebroomwoodhealthcentre.co.uk**](http://www.thebroomwoodhealthcentre.co.uk)

**NEW PATIENT QUESTIONNAIRE**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ABOUT YOU – THE PATIENT**

Surname:………………………………………. Forenames: …………………………………………...........

Date of birth (dd/mm/yyyy): …………………………………..…………………………………………………..

Gender: …………………………………………… NHS Number: ……………..………………………………

Occupation: ……………………………………………………………………………………..…………...........

School currently attended – under (if applicable): ……………………………………………..………………

**CONTACT INFORMATION**

Address: ……………………………………………………………………………………………………………

………………………………………………………………………………………………………………………

Postcode: ………………………………………………………………………………………………………….

Telephone Number: …………………………………. Mobile Number: ………………………………………

Email (PLEASE WRITE CLEARLY: ……………………………………………………………………………

**CONTACTING YOU**

We will use your contact details to send reminders about appointments, reviews and other services which may be of benefit in your medical care.

**If you DO NOT consent to receive text reminders/messages to your mobile, please tick this box:** [ ]

**If you DO NOT consent to us sending messages to you via email, please tick this box:** [ ]

\*\*We will not leave detailed messages on your phone, but may ask you to contact us or leave a simple message if we do not need to speak to you\*\*

**TO BE COMPLETED FOR ONLY UNDER 16YRS**

Parent/Guardian (Mother Name)……………………………………………………………………………

Tel No:…………………….....................................................................................................................

Address: …………………………………………………………………………………………………..……

Next of Kin: Yes [ ]  No [ ]

Emergency contact: Yes [ ]  No [ ]

Can discuss record: Yes [ ]  No [ ]

Parent/Guardian: (Fathers name as on Birth Certificate)………………………………………………....

TelNo:……………………......................................................................................................................

Address: ……………………………………………………………………………………………………….

Next of Kin: Yes [ ]  No [ ]

Emergency contact: Yes [ ]  No [ ]

Can discuss record: Yes [ ]  No [ ]

Other Next of Kin: ………………………………Relationship to patient: ……………………………….

Tel No:…………………….....................................................................................................................

Address:………………………………………………………………………………………………………...……...…………………………………………………………………………………………………………...

Next of Kin: Yes [ ]  No [ ]

Emergency contact: Yes [ ]  No [ ]

Can discuss record: Yes [ ]  No [ ]

**SAFEGUARDING**

Are you or have you been a looked after child? Yes [ ]  No [ ]

Are you or have you been on a child protection plan? Yes [ ]  No [ ]

Are you or have you been considered a child in need? Yes [ ]  No [ ]

**RESIDENCY**

Previous Address in the UK (if applicable): ……………………………………………………………………

………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………

If you are from abroad, what date did you come to the UK? ...................................................................

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DISABILITES / ACCESSIBLE INFORMATION STANDARDS**

As a practice we want to make sure that we give you information that is clear to you. For that reason we would like to know if you have any communications needs or any disabilities.

**Do you have any communication needs? Yes** [ ]  **No** [ ]

If **YES**, please state your needs: …………………………………………………………………………………………………………………

**Do you have any significant mobility issues? Yes** [ ]  **No** [ ]

If **YES**, please give details: ………………………………………………………………………………………………………………..

**Do you consider yourself to have a Special Education Need or Disability?**

**Yes** [ ]  **No** [ ]

If **YES**, please give details: ………………………………………………………………………………………………………………..

**Do you currently have an Educational Health Care Plan (EHCP) ? Yes** [ ]  **No** [ ]

**Do you need special arrangements to be in place when contacting / visiting the surgery? Yes** [ ]  **No** [ ]

If **YES**, please give details: ………………………………………………………………………………………………………………..

………………………………………………………………………………………………………………..

Are you housebound? **Yes** [ ]  **No** [ ]

Are you blind / partially sighted? **Yes** [ ]  **No** [ ]

Do you have any problems with your hearing? **Yes** [ ]  **No** [ ]

If **YES**, please give details: …………………………………………………………………………………………………………………..

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ETHNICITY**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **White British** |  | **Indian** |  | **Other White** |  | **African** |  | **Chinese** |  |
| **White Irish** |  | **Pakistani** |  | **Other Asian** |  | **Caribbean** |  | **Prefer Not to say** |  |
| **White Scottish** |  | **Bangladeshi** |  | **Other Mixed** |  | **Other Black**  |  |
| **Please state other Ethnic Origin:**  |

**1st Main Language:** ………………………………………………………………………………………

**2nd Language:** ………………………………………………………………………………………….......

Interpreter Required: **Yes** [ ]  **No** [ ]

**SERVICE FAMILIES AND MILTARY VETERANS**

As a practice, we fully support the Armed Forces covenant. We can only do this if we know our patients connections to the Armed Forces. Please tick the relevant box below which applies to you.

|  |  |  |  |
| --- | --- | --- | --- |
| **I AM** a Military Veteran |  | **I AM** Currently serving in the Reserve Forces |  |
| **I AM** married/civil partnership to a serving member of the Regular/Reserve Armed Forces |  | **I AM** married/civil partnership to a Military Veteran |  |
| **I AM** under 18yrs and my parent(s) are Serving members of the Armed Forces |  | I AM under 18yrs and my parent(s) are veterans of the Armed Forces |  |

**CARERS AND NEXT OF KIN DETAILS**

**Name of Next of Kin: Mr/Mrs/Miss**………………………………………………………………………

**Relationship to Patient:** …………………………………………………………………………………..

**Address:** ……………………………………………………………………………………………………..

**Tel No:** …………………………………………………………………………………………………………

**Emergency Contact:** Yes [ ]  No [ ]

**Can discuss record:** Yes [ ]  No [ ]

**By ticking these boxes and signing below you agree for your medical record to be discussed with the above named person**

**Signed:** ……………………………………………………………..…… **Date** …………………………….

**Are you a carer? Do you care for a relative/friend?**  Yes [ ]  No [ ]

**If YES, please give details**………………………………………………………………………………….

**DONATION WISHES**

If you live in England, Wales or Jersey, are not in a group excluded from Opt Out legislation and you have not registered an organ donation decision, it will be considered that you agree to be an organ donor. This is known as deemed consent.

If you **DO NOT** want to donate your organs then you should register your decision. To Opt Out, visit https:ardens.live/Organ-donation-opt-out

Do you have a donor card or are you on the organ donor register? Yes [ ]  No [ ]

Have you Opted Out? Yes [ ]  No [ ]

Are you a blood donor? Yes [ ]  No [ ]

**RESUSCITATION WISHES AND POWER OF ATTORNEY**

Do you have a DNACPR (Do not Attempt to Resuscitate) form in place? Yes [ ]  No [ ]

Does anybody hold a lasting Power of Attorney for Health and Welfare for you?

 Yes [ ]  No [ ]

If Yes, who is this…………………………………………………………………………………………

**MEDICATION AND ALLERGIES**

**Regular Medication** or provide a copy of your repeat medication slip or list our medication here………………………………………………………………………….……………………………

………………………………………………………………………………………………………………………

**ELECTRONIC PRESCRIBING SERVICE (EPS)**

The EPS service allows prescribers such as GPs/Clinicians and practice nurses to send prescriptions electronically to your nominated chemist. This makes prescribing and dispensing process more efficient and convenient for patients and staff. The NHS aim that

Would you like to nominate a pharmacy for your prescriptions to be sent electronically?

**Yes** [ ]  **No** [ ]

If yes, name of pharmacy: …………………………………………………………………………………

**DRUG ALLERGIES OR REACTIONS**

……………………………………………………………………………………….......................................

**PAST ILLNESSES/OPERATIONS** ………………………………………………………………………………...................................................

……………………………………………………………………………………………………………………

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HIV STATUS**

**Do you know your HIV status: YES** [ ]  **NO** [ ]

If no, we can offer a confidential free HIV test, please tick here if you would like to be tested [ ]

If you are aged 16-24yrs old, you are entitled to a free Chlamydia testing kit.

Please tick the box if you would like a free kit [ ]

**CHLAYMDIA TESTING KITS**

**If you are aged 16-24 years old, you are entitled to a free Chlamydia testing kit.**

**Please tick the box if you would like a free kit** [ ]

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HISTORY OF CHRONIC DISEASES – Please tick in the box if YOU suffer from any of the following diseases:**

Coronary Heart Disease [ ]  Heart Failure [ ]

Left ventricular dysfunction [ ]  Chronic Kidney Disease [ ]

Diabetes [ ]  Hypertension [ ]

Stroke & Transient Ischaemic Attack [ ]  Epilepsy [ ]

COPD or Asthma [ ]  Cancer [ ]

Dementia [ ]  Mental Health [ ]

Depression [ ]  Obesity [ ]

Learning Disabilities [ ]  Hypothyroidism [ ]

**If you have ever had Cohn’s or ulcerative colitis in the past it is important that you have regular follow up from a Gastroenterologist EVEN IF YOU ARE NOW WELL.**

**Please make an appointment with your GP to discuss.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY**

Do any of your immediate family members suffer with any of the above Chronic Diseases or a sudden unexpected death? If so, please give details below:

Family member …………………………………. Chronic Disease ………………………………………..

Family member ………………………………… Chronic Disease ………………………………………..

…

Family member ………………………………….Chronic Disease …………………………………………

If no family history tick here [ ]

**SMOKING STATUS**

Do you smoke: **YES** [ ]  **NO** [ ]  If yes number of cigs/ozs of tobacco per day: …………….

Are you an ex-smoker? **YES** [ ]  **NO** [ ]  Approx date stopped: ………………………………………..

Do you use electronic cigarettes/vape? **YES** [ ]  **NO**

Smoking is the UK’s single greatest cause of preventable illness. Stopping smoking is not easy, but it can be done, and there is now a comprehensive, NHS Smoking Cessation Service offering support and help to smokers wanting to stop, with cessation aids available on NHS Prescription

If you would like help and advice on how to give up smoking, please contact www.nhs.uk/live-well/quit-smoking/nhs-stop-smoking-services-help-you-quit/

**HEIGHT / WEIGHT / BLOOD PRESSURE**

**Please use the machine in the surgery or you can use you home readings**

What is your height? ……………………………..

What is your weight? …………………………….

What is your Blood Pressure? ………………….

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FOR FEMALE PATIENTS ONLY:**

**Are you currently pregnant? Yes** [ ]  **No** [ ]

If YES, please ensure you are under the care of the midwife. If not, you can self-refer [www.kch.nhs.uk/formspruhantenatal](http://www.kch.nhs.uk/formspruhantenatal)

**Are currently using contraception? Yes** [ ]  **No** [ ]

**If yes, which method of contraception are you using?** ………………………………………………

**Do you currently have a long acting reversible contraception (implant/coil) in place?**

**Yes** [ ]  **No** [ ]

**If YES, when was it fitted? (dd/mm/yyyy)** …………………………………………………….

**When was the date of your last smear?** ……………………………………………………..

*(If exact date unknown year would be sufficient)*

**Have you had a hysterectomy? Yes** [ ]  **No** [ ]

**Do you still have your ovaries? Yes** [ ]  **No** [ ]

**Do you have any children under the age of 16yrs? Yes** [ ]  **No** [ ]

If YES, Please state name and date of birth for all children (even if not living with you)?

Child 1. Name …………………………………………………………… Date of Birth………………….

Resides at same address **Yes** [ ]  **No** [ ]  If no, what address………………………………….

Child 2. Name …………………………………………………………… Date of Birth………………….

Resides at same address **Yes** [ ]  **No** [ ]  If no, what address………………………………….

Child 3. Name …………………………………………………………… Date of Birth………………….

Resides at same address **Yes** [ ]  **No** [ ]  If no, what address………………………………….

Child 4. Name …………………………………………………………… Date of Birth………………….

Resides at same address **Yes** [ ]  **No** [ ]  If no, what address………………………………….

**IMMUNISATIONS AND VACCINATIONS**

Please add your **Adult/Childhood** immunisations here. **If you are under 16yrs** you will find your immunisation data in your Red Book, please bring this with you when registering. We will photocopy this for our records

|  |  |
| --- | --- |
| **Immunisation** | **Date** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**ALCOHOL CONSUMPTION – OVER 16YRS ONLY**

**This is one unit of alcohol…**

****

**…and each of these is more than one unit**

****

**AUDIT – C**

|  |  |  |
| --- | --- | --- |
| **Questions** | **Scoring system** | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| **How often do you have a drink containing 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 - 9** | **10+** |  |
| **How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?** | **Never** | **Less than monthly** | **Monthly** | **Weekly** | **Daily or almost daily** |  |

**SCORE**

**Scoring:**

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

An overall total score of 5 or above is AUDIT-C positive.

If you would like help and advice on how to reduce your alcohol intake, please contact [www.drinkaware.co.uk](http://www.drinkaware.co.uk) or ask at reception

**SCR (SUMMARY CARE RECORD)**

**What is a Summary Care Record?** This is short summary of your GP Medical Records which is electronic. It will contain important information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines that you have had. It will also include basic information about your current problems. Giving healthcare professionals access to this information can help with any emergency treatment you may require out of hours. Your summary care record will also include your name, address and contact details, therefore please ensure you keep these up-to-date by informing the surgery of any changes as soon as possible.

There are **two** different types of Summary Care Record (SCR)

**A Core Data SCR** - tells other Healthcare professionals who are caring for you about the medicines you take and any allergies you may have. This means they can give you better care if you need health care away from your usual doctor’s surgery in an emergency, when you’re on holiday, when your surgery is closed, at outpatient clinics or when you visit a pharmacy.

**A Core Data Plus additional SCR** – you can add more information to your SCR by requesting this option. This can include health problems like Dementia or Diabetes, details of your carer, your treatment preferences or your communication needs, for example if you have hearing difficulties or need an interpreter.

**Please tick one of the following options:**

I give consent for my core data to be uploaded to the National Spine. **YES** [ ]  **NO** [ ]

I give consent for my core data plus additional information to be uploaded to the National Spine. **YES** [ ]  **NO** [ ]

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NHS DIGITAL (FORMERLY KNOWN AS HSCIC) HEALTH & SOCIAL CARE INFORMATION CENTRE**

**What is NHS Digital?** HSCIC, now NHS Digital, is the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care. Its work includes publishing more than 260 statistical publications per year, providing a range of data services, managing informatics projects and developing and assuring national systems against appropriate contractual clinical safety and information standards. The new name of ‘NHS Digital: Information and technology for better health and care’ should help to build public recognition, confidence and trust.

Is a trusted source of authoritative data and information relating to health and care, NHS plays a fundamental role in driving better care, better services and better outcomes for patients. It supports the delivery of IT infrastructure, information systems and standards to ensure information flows efficiently and securely across the health and social care system to improve patient outcomes. Established on the 1st of April 2013, HSCIC's remit was outlined in the Health and Social Care Act 2012 and the Government's recent information strategy for health and care in England.

The National Data Opt-Out choice must now be set by you. To choose your preference for your confidential patient information status you must do this yourself by visiting [www.nhs.uk/your-nhs-data-matters](http://www.nhs.uk/your-nhs-data-matters). **You will need your NHS Number to do this so please ask the receptionist if you do not know this number**

**Please be aware until you have set your choice your confidential patient information may still be used for research and planning.**

**FOR OFFICE USE ONLY**

**THINGS TO CHECK WHILST PATIENT IS IN THE SURGERY**

|  |  |
| --- | --- |
| 1. BP/Height/Weight Done (OVER 16YRS ONLY)
 | **YES** [ ]  **NO** [ ]  |
| 1. Patient informed of registered GP but can also see any GP
 | **YES** [ ]  |
| 1. Text messaging preference checked:
 | **YES** [ ]   |
| 1. Name of school section completed
 | **YES [ ]**  **N/A** [ ]   |
| 1. Alcohol consumption form completed
 | **YES [ ]**   |
| 1. Chlamydia screening kit given (16-24yrs)
 | **YES** [ ]  **NO** [ ]  **N/A** [ ]   |
| 1. Smoking Advice leaflet given:
 | **YES** [ ]  **NO** [ ]  **N/A** [ ]   |
| 1. Summary Care record preference
 | **YES** [ ]   |

**REGISTRATION CHECKED BY**

**Receptionist Initials………………Date:……………………..**

**ONCE ADDED TO COMPUTER SYSTEM:**

|  |  |
| --- | --- |
| 1. Book appointment for health check if patient has requested this
 | **YES** [ ]  **NO** [ ]  **N/A** [ ]  Date of Appt:…………… |
| 1. Nominated pharmacy added to computer
 | **YES** [ ]  **NO** [ ]  **N/A** [ ]    |
| 1. If the HIV section has been ticked, have you sent a letter with the relevant blood forms?
 | **YES** [ ]  **NO** [ ]  **N/A** [ ]   |
| 1. If the Chlamydia Testing section has been ticked (16-24yrs olds ONLY), if not contact patient to collect test
 | **YES** [ ]  **NO** [ ]  **N/A** [ ]    |
| 1. Smoking Advice leaflet given:
 | **YES** [ ]  **NO** [ ]  **N/A** [ ]    |
| 1. GP2GP RECORDS TRANSFERRED & CODE 9b08 ADDED
 | **YES** [ ]  |
| 1. If proof of ID provided Authorise and send Internet Access
 | **YES** [ ]  **NO** [ ]  |

**REGISTERED BY**

**Receptionist Initials ………………Date:……………………………………..**