Millcroft Medical Centre

**Eagle Bridge Health & Wellbeing Centre**

**Dunwoody Way, Crewe**

**Cheshire, CW1 3AW**

**Telephone**: (01270) 275200 (all enquiries) **Cancellations** : (01270) 275199

**Website** : [www.millcroftmedicalcentre.nhs.uk](http://www.millcroftmedicalcentre.nhs.uk)

**New Patient Health Questionnaire For Adults**

**Your Contact Details**

|  |  |
| --- | --- |
| Title: | D.O.B: |
| Full Name:  Previous Surname: | NHS Number: |
| Home Address:  Home Tel No:  Place of Birth: | E-mail Address:  Mobile No: |
| Your prescription will be sent via our Electronic Prescribing Service (information available at reception) please nominate your pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If you were **NOT** born in the UK, what was the date you came to live in the UK: | |

**Were you ever registered with an Armed Forces GP**

|  |
| --- |
| Please indicate if you have served in the UK Armed Forces and/or been registered with a Ministry of Defence GP in the UK or overseas: |
| Regular  Reservist  Veteran  Family Member (Spouse, Civil Partner, Service Child)  Address before enlisting:  Service or Personal number: Enlisting date: Discharge date  Footnote: These questions are optional and your answers will not affect your entitlement to register or receive services from the NHS but may improve access to some NHS priority and service charities services. |

**Information about You**

|  |  |  |
| --- | --- | --- |
| Height: | Weight: | Main Language: |

**Ethnic Background**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **White:** | British | Irish | Other |  |
| **Black:** | Caribbean | African | Other |  |
| **Asian:** | Indian | Pakistan | Chinese | Other |
| **Mixed:** | White and Black Caribbean | White and Black African | White and Asian | Other |
| What is your main spoken language? | | | | |
| Do you require an interpreter? Yes  No  If Yes what language:  Are you an Asylum Seeker? Yes  No  (Answering this question will not affect your registration with the practice) | | | | |

**Previous Address Details:**

|  |  |
| --- | --- |
| Name: | Address: |

**Previous GP Details:**

|  |  |
| --- | --- |
| Name: | Address: |

**Women only**

|  |
| --- |
| Have you ever had a cervical smear?  Yes  No  If yes please state when and where: |

**Smoking**

|  |
| --- |
| Do you smoke?  Yes  No  Have you ever smoked?  Yes  No  E-Cigarette?  Yes  No  If you are a smoker how many cigarettes do you smoke per day? ……………………  Would you like advice on giving up smoking? Yes  No |
|  |

**Alcohol**

|  |  |
| --- | --- |
| **Alcohol Questions** |  |
| How many units of alcohol do you drink per week? |  |

**Next of Kin**

|  |
| --- |
| We need contact details for your next of kin in case of emergency:  Title: First name: surname:  Address:  Tel No:  Relationship to you: |

**Information or communication needs**

|  |  |  |
| --- | --- | --- |
| What is your preferred communication method? | | |
| Letter to Home Address  Email Address | Telephone call  Any communication method | SMS text message |
| Do you suffer from impaired vision?  Yes  No  If yes, would you prefer to receive communication in a different way?  Yes, please specify ………………………………………………………  No | | |

**Medical Information**

|  |  |  |
| --- | --- | --- |
| We need to know of any medical problems you may have or have had so we can provide better care for our patients. Please answer all the questions below with as much detail as you can.  Have you ever suffered from any of the following? | | |
| Epilepsy | Asthma | Bipolar |
| High Blood Pressure | Eczema | Glaucoma |
| Heart Attack | Blindness | COPD |
| Depression: | Diabetes | Hay Fever |
| OCD: | Stroke |  |
| Cancer: | Anxiety |  |
| Are you on any long-term treatment or medications from any other services? Please detail below: | | |
| Please list any operations, accidents, disabilities, problems in pregnancy or illnesses and the year they took place if not previously mentioned. | | |
| Are you registered disabled?  Yes  No  If yes please give details | | |
| Are you allergic to any medications?  Yes  No  If yes please give details | | |
| Have you ever refused treatments or screening of any kind?  Yes  No  If yes please give details | | |
| Have you ever suffered from any other mental health illnesses?  Yes  No  If yes please give details | | |
| Please list all medication that you are currently taking along with Dose and Frequency | | |
| Do you have a carer?  Yes  No  Are you a carer?  Yes  No  Do you have a living will?  Yes  No | | |

**Family History**

|  |  |  |
| --- | --- | --- |
| Has anyone in your family had any serious illnesses such as: | | |
| Cancer | Relation: | Type: |
| Heart Disease | Relation: | |
| Stroke | Relation: | |
| High Blood Pressure | Relation: | |
| Diabetes | Relation: | Type: |
| Other Inherent illness | Relation: | Illness: |
| Have you ever had a Flu Vaccination?  Yes  No  If yes please provide a date:  Have you ever had a Pneumococcal Vaccination?  Yes  No  If yes please provide a date: | | |

**Please hand this form into reception along with your new patient Registration form.**

Summary Care Record Data is uploaded from your GP practice to create your Summary Care Record (SCR). Your SCR contains important information about your medication, allergies, and reactions to medicines that you have had. This information can then be used when caring for you in an emergency, when your GP practice is closed or when you are away from home elsewhere in England. Your Summary Care Record will also include your name, address, date of birth and your unique NHS Number to help identify you correctly. You may want to add other details about your care to your Summary Care Record eventually. Healthcare staff will ask your permission every time they need to look at your Summary Care Record. If they cannot ask you, e.g. if you are unconscious, healthcare staff may look at your record without asking you. If they have to do this, they must record the reason on your record

**PLEASE TICK THIS BOX IF YOU DO NOT** wish to share your medical record for the purpose identified above

|  |  |
| --- | --- |
| **Sign:** | **Date:** |