Dr LM Taylor & Partners

Adult New Patient Questionnaire

Today's Date

Please complete this confidential questionnaire. Information provided on this form will be added to your clinical records unless you let the receptionist know otherwise.

Does the chemist order / deliver your prescriptions Yes / No (please circle)
If you answered 'YES' what is the name and address of the chemist:

Full Name: Mr / Mrs / Miss / Ms / Other NHS No:	Place of Birth	Date of Birth: Over 75 years ☐	Gender: Male / Female

Have you registered with a GP in ENGLAND in the past? Yes / No GP name/address	Can we text you? Yes / No Can we inform you of your results by text? Yes / No
Current address and Postcode: Previous Address:	Telephone numbers: Home Mobile Work

Housebound patients – do you have any specific arrangements for access? e.g. key codes, key holders, etc
Please give details below.

Have you ever served in the British Military: Yes / No	If 'yes' were you in the British Army, Navy or Air force: Can we add this information to your medical records? Yes / No
Enlistment date:	Address before enlisting:
Your job: Your partner's job:	Next of Kin and relationship: Next of Kin contact number:

Can we leave telephone messages for you? (This will remain in force until you inform us you wish to cancel)	Yes I give consent to leave messages on my phone Signed……………………………………………….Date……………	No I do not give consent to leave messages.

Your Ethnic Origin: (circle one)	White (UK)	White (Irish)	White (Other)	Chinese	Asian	Pakistani / Brit Pakistani	Indian / Brit Indian
Bangladeshi / Brit Bangladeshi	African	Caribbean	Other Black Background	Other Mixed Background		Other Asian Background	Other ethnic origin

Your main or 1st language Spoken / Understood:	Please state:	Do you require the help of a translator?	Yes / No

Your Religion:	C of E	Catholic	Other Christian (state)	Buddhist	Hindu	Muslim
	Sikh	Jewish	Jehovah's Witness	No religion	Other religion (state)	

Smoking, Alcohol Consumption and Exercise:

Are you a smoker?	Yes No	If 'yes' how many a day …………………..	Have you ever been a smoker?	Yes	No	Date Stopped smoking:

Its NEVER too late to stop smoking you will ALWAYS benefit! Call ***0800 169 4219 for help today!***

How many times do you exercise per week?		Type(s) of exercise:

If you would like help and support with stopping smoking, losing weight or reducing your alcohol intake please ask the receptionist or health care assistant/nurse.

Your Medical History:

What illnesses have you had & When?	

Are there any medications you have been advised NOT to take?	(Please list)
Why can't you take this medication?	
What operations have you had and When?	
Do you have any medical problems at present?	
Please list any tablets, medicines, other treatments you are currently taking: (incl. dose + frequency)	
Have you ever been a drug abuser?	

Are there any serious family diseases that affect your parents, brothers or sisters. (tick all that apply)						
	Diabetes	**Heart attack**	**Heart attack under age 60**	**Bowel Cancer**	**Glaucoma**	**Asthma**
	Breast cancer	**Stroke**	**High blood pressure**	**Thyroid disorder**	**Any other important family illness?**	

If you provide help or support to a family member, friend or child who because of physical, mental illness, substance misuse, disability or old age, could not manage without you – YOU are a CARER.

Are you a carer?	**Yes / No**	**Is the cared for person registered with this practice?**	**Yes / No**
If the person you care for consents please supply a contact number and name in case of emergency.	**Emergency name/contact number for cared for person:**		
	Carers Leeds provide support and advice on a range of matters for carers. If you would like to be referred to Carers Leeds please tick box below ☐		

If you have a Carer, please state their name/address/phone number and sign here if you wish us to disclose information about your health to your Carer.	**Carer contact details (please get consent from your carer to provide this information).**	**Carer consent given** **YES / No**
	Signed:……………………………………………………………………Date ……………………	

Do you have a "Living Will"
(a statement explaining what medical treatment you would not want in the future)
Please tick box Yes ☐No ☐
If you have answered 'YES' can we have a written copy to scan into your medical records

Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)?	**Yes / No**	***If "Yes", please state their name / address / phone number***

Specific Needs: Please detail below any specific needs for example communication needs, you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:	
Please state any Sensory Impairment you have (i.e. Speech, Hearing, Sight):	
Are you an 'Guide Dog/Assistance Dog' User?	
Please state any Physical or Mental disabilities you have:	
Please state any communication needs e.g. require large print, speak loudly, text message, email, telephone, verbal information, language line.	
Please state any requirements you have to be able to access the Practice premises	
Please state any Religious or Cultural needs:	

Women only: If your last smear test was NOT done at your GPs please tell us when and where you had it and, if possible, please provide a copy of it.

Date of was last smear?	Date	Where was this done? e.g. work, abroad, private clinic		I do not have a copy of my last smear but confirm the details given are correct. Signed………………………………………………….

A smear test is a quick, simple screening test to detect cervical cancer. It is offered to women over 25 years old and is performed by the nurse every three or five years. .Please ask a member of staff if you have never had one or are overdue for one.

Method of contraception (if used):	

Sharing Medical Information.

The NHS are changing the way your health information is stored and managed.
The practice now keeps computerised medical records for all its patients.
We will share this information with other health providers you may be seeing e.g. district nurses, health visitors, physiotherapists etc. If you do not wish us to share your information please inform the receptionist.

Virtual Patient Opinion Forum

The Practice is committed to improving the services we provide to our patients.
To do this, it is vital that we hear from people about their experiences, views, and ideas for making services better.
By expressing your interest, you will be helping us to plan ways of involving patients that suit you.
If you are interested in finding out more about our Virtual Patient Opinion Forum please tick the box below.

Yes, I am interested in becoming involved in the Virtual Patient Opinion Forum.	Yes

Patient Signature:		Signature on behalf of Patient:	

Your physical examination will include having your height, weight and blood pressure taken, and a specimen of urine for testing (it would be helpful if you would bring a specimen with you when coming to the Practice).

Audit C Alcohol Screening Questions

Please read the following questions and tick the box which most applies.

1 unit = ½ pint of beer, OR 1 glass of wine OR one single glass of spirit.

How often do you have a drink containing alcohol?	Never	Monthly or less.	2 – 4 times month	2-3 times a week	4 or more times a week
How many units of alcohol do you drink on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 or 9	10 or more
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
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session.	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost Daily
Have you or somebody else been injured as a result of your drinking?	No	Yes, but not in the last year.		Yes, during last year.	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?	No	Yes, but not in the last year.		Yes, during last year.	

Thank you for completing these forms

For more information about the services we offer, please refer to our practice leaflet or see our website:Shaftesbury-churchview.co.uk