New Patient Questionnaire

Maple Surgery

If you need any support completing these forms please ask our reception teams who will be happy to help you. Please ensure you complete the Purple GMS (General Medical services) form clearly at the front of this leaflet.

You can obtain your NHS number from your previous GP surgery.

We do understand that not all questions on our registration forms are applicable to all patients. However it is important we use the registration process to capture as much information as possible. This is to ensure that we are offering you the best standard of care and can signpost patients who may need extra support at the point of registration. Please complete the registration forms to the best of your knowledge with as much information as possible.

PATIENT NAME	**DOB**

We recommend that patients provide identification when registering at the practice. If you're unable to provide identification we can still register you. However you won't be able to access our online services without proof of identification.

We do recommend patients sign up for online services.

Have you been registered with our GP Practice before? Yes ☐ No ☐

If you have previously been de-registered under our zero-tolerance scheme you must not register with our practice, without first writing to the Practice Manager with your request. If the practice declines your request to register they will inform you in writing of the decision. The practice has a right to remove your registration at their discretion at any time if you have previously been removed from our list for abusive behavior and not informed them at the point of re-registering.

I wish to have access to the following online services (please tick all that apply):

1. Booking appointments ☐
2. Requesting repeat prescriptions ☐
3. Accessing my medical record ☐

Please provide photographic identification and proof of address to register with our online services.

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TEL No (home):	TEL No (work):
TEL No (mobile)	EMAIL ADDRESS
Consent for SMS messages Do you consent to us contacting you by SMS messages Yes ☐ No ☐	Consent for email correspondence Do you consent to us contacting you by email Yes ☐ No ☐
NEXT OF KIN: Name Address (including postcode) Contact number Your relationship --- Would you like to be provided with an ACP booklet (Advanced Care Planning) Yes ☐ No ☐ Advance care planning is a process that enables individuals to make plans about their future health care.	
Name & address of Nominated Pharmacy for prescriptions	

SUMMARY CARE RECORD

Your records will automatically be coded for an Enhanced Summary Care record. If you do not want a summary care record, please ask at reception for an OPT out form and tick here ☐

Your Summary Care Record is a short summary of your GP medical records. It tells other health and care staff who care for you about the medicines you take and your allergies. It means they can give you better care if you need health care away from your usual doctor's surgery: for example, in an emergency, when you're on holiday, when your surgery is closed, at out-patient clinics or when you visit a pharmacy.

THIRD PARTY ACCESS

In the Practice we aim to provide you with the highest quality of healthcare. To do this we must keep records about you, your health and the care we have provided or plan to provide to you. Everyone working for the NHS has a legal duty to keep information about you confidential. If you would like a family member or carer to have access to your medical records on your behalf. We need to keep their contact details on your records.

The person you nominate must be happy to have their details recorded in your medical records. If you wish to nominate someone for this reason please provide us with their details and sign below that you consent to this

Name of nominated individual _____

Your signature _____ Date _____

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First Spoken Language?	English	Other (please state) do you require an interpreter?	

What is your ethnicity?	British	Irish	Other White	Mixed	Indian	Pakistani
	Asian	British Asian	Black	African	Other Black	Chinese
	Bangladeshi	Other Asian	Caribbean			

LIFESTYLE

Blood pressure reading (please use pod in reception if available)	

HEIGHT:		WEIGHT:		
DO YOU SMOKE? NEVER / EX-SMOKER / YES*			HOW MANY PER DAY?	
Do any of the following apply	Pipe	Roll ups	Vaping	Cannabis

Would you like help to stop smoking	Yes	Not at this time

PERSONAL MEDICAL HISTORY
(please tick any that are relevant and write the date of diagnosis where possible)

ANGINA	ARTHIRITIS	ASTHMA
CANCER	DIABETES	EPILEPSY
HIGH BLOOD PRESSURE	LEARNING DISABILITIES	OSTEOPOROSIS
MENTAL HEALTH SUPPORT	SKIN DISEASE	THYROID DISEASE
COPD	OTHER -	
Please list medicines taken for the conditions above		

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FAMILY HISTORY

HEART PROBLEMS (i.e. ANGINA/HEART ATTACK)	YES / NO	RELATIONSHIP / AGE:
STROKE (CVA)	YES / NO	RELATIONSHIP / AGE:
CANCER	YES / NO	RELATIONSHIP / AGE:
DIABETES	YES / NO	RELATIONSHIP / AGE:
ASTHMA	YES / NO	RELATIONSHIP / AGE:

MEDICATION

Medication: If you are taking regular medication from your previous GP you will need to book an appointment before our G.P's can issue this, please allow yourself plenty of time so you do not run out of medication and bring along any previous prescription requests / medication with you to the appointment. Please note we do not accept prescription requests over the phone unless you are housebound and prescriptions take 48 hours to be processed.
LIST ANY OVER THE COUNTER MEDICATION USED REGULARLY
PLEASE ADVISE OF ANY KNOWN ALLERGIES

New Patient Health Check

Would you like to be booked an appointment for a new patient health check with our Practice Nurse? You can choose at the appointment to have a quick and simple test for HIV if you wish to do so. As part of your registration process please advise us if you would like to opt out of this

I would like to be booked an appointment for a new patient health which will include the option of a HIV test	Yes ☐ No ☐

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VETERANS

ARE YOU OR HAVE YOU SERVED IN THE ARMED FORCES ? What is your service number ……..	Yes	No

CARERS

ARE YOU A CARER FOR SOMEONE ELSE?	Yes	No

IS THERE SOMEONE YOU RELY ON FOR YOUR CARE? (please circle)	Family	Friend	Paid carer	Social care support

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WOMEN ONLY

I HAVE HAD A HYSTERECTOMY AND THEREFORE DO NOT REQUIRE A SMEAR TEST	☐

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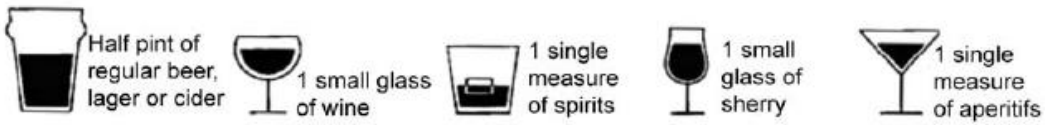
DO YOU DRINK ALCOHOL – Please complete below by circling your answers

FAST	Scoring system					Your score
	0	1	2	3	4	
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	
Only answer the following questions if the answer above is Never (0), Less than monthly (1) or Monthly (2). Stop here if the answer is Weekly (3) or Daily (4).						
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 been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

This is one unit of alcohol…



…and each of these is more than one unit

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LOOKED AFTER CHILDREN

Patients aged 13 – 21 years – are you currently a looked after child **(LAC) under the local authority or in foster care**	YES	NO

COMMUNICATION

We want to make sure you can read and understand the information we send you. If you find it hard to read letters or if you need someone to support you at appointments, please let us know in the answers given below.

Patients with hearing impairment

Do you lip-read or use a hearing aid or other communication tool?	YES	NO
IF SO, WHICH?		

Do you need a British Sign Language interpreter or advocate with longer appointment times?	YES	NO
IF YES, WHICH?		

Patients with visual impairment

Do you need information in another format? For example, large print or easy to read?	YES	NO
IF YES, WHICH?		

All patients

How would you prefer us to communicate with you? (PLEASE CIRCLE)	LETTER	EMAIL	TEXT	OTHER
IF OTHER, PLEASE STATE HOW?				

Is there any other communication support we should provide for you?	YES	NO
IF YES, PLEASE STATE?		

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Consent

I consent to the practice contacting me by text message and/or email message for the purposes of health promotion and for appointment reminders.

I acknowledge that appointment reminders by text and/or email are an additional service and that these may not take place on all/or on any occasion and that the responsibility of attending appointments or cancelling them still rests with me. I can cancel the text and/or email message facility at any time.

Text messages are generated using a secure facility however I understand that they are sent over a public network onto a personal telephone and as such may not be secure, however the practice will not transmit any information which would enable an individual patient to be indentified.

I agree to advise the practice if my email address changes and also if my mobile telephone number changes or if this is no longer in my possession.

The practice does not share mobile phone contact details or email addresses with any external non-NHS organisation.

Your medical records may be used for financial or clinical audit, post payment verification checks, medical research or education purposes.

Signature	Date

I confirm that the information given above is accurate to the best of my knowledge and that I live within the practice boundary catchment area as detailed in this pack and I confirm that I have read and understood the **Contract of care** provided in this pack.

Signature	Date

Do you live in a care home?	Yes	No

Alternatively if you are homeless or at risk of homelessness please complete the information below. The reason we ask for this information is so that we can send a referral to the local homelessness team

Are you homeless Do you give your consent for a referral to homelessness team	Yes Yes	No No
Are you threatened homelessness	Yes	No
What date do you expect to become homeless		
National insurance number		

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Current living situation	You	☐
	Couple	☐
	Family with dependents	☐
	Family with no dependents	☐

Owner	Private rented	Council tenant	Housing Association tenant	Living with parents
Staying with friends	Sleeping rough	Hostel	Night shelter	other

Please be aware once the referral has been sent, the practice will be unable to provide you with further information regarding the referral .The homelessness team will contact you directly

You can only register at our practice if you live within the catchment area for our practice. Please speak to our practice staff for clarification.

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Contract of Care

The GPs, Nurses, Practitioners and Staff aim to provide the highest possible care to our patients. The aim of this Contract of Care is to ensure that you understand the practice policies, why such policies are in place and then follow them. We particularly recommend that you read closely the details relating to our Appointment, Repeat Prescribing and Behaviour expectations.

Your responsibilities:	**Practice responsibilities:**
Comply with recommended treatment	Offer access to quality medical services
Participate in appropriate screening and prevention programmes	Provide you with an appointment with a GP or appropriate healthcare professional or signpost you to a suitable alternative service in line with our appointments procedure
Commit to a healthy lifestyle with support from the Practice if required.	Enable you to relevant appointments with the right clinician the first time
Treat clinicians and staff with dignity and respect at all times.	Treat you with dignity and respect at all times.
Be aware of our practice booking system and use this appropriately and book with the appropriate clinician.	Ensure all patients have access to a patient information leaflet which includes information of how to book an appointment.

Information about all the services we provide are detailed on our website If you do not have access to the internet please ask at reception for a practice leaflet. Before deciding that you wish to join the Practice we ask that you review this information in order to decide whether you can follow the policies presented by the Practice in line with the General Medical Services GP contract.