NEW PATIENT QUESTIONNAIRE

PERSONAL DETAILS

Name …… Date of birth …… /…….. /……..

Address ……

…….. Postcode ……..

Home telephone …….. Mobile telephone ……

I do/do not* consent to receiving SMS text messages from the surgery to my mobile telephone (**please delete as appropriate*)

Email address ……

By providing your email address you are consenting to receive information from the surgery to your email address. *Only consent to receiving emails if you do not share your email address/account with another adult and regularly check your email inbox for new messages.*
You will receive an initial message requesting verification of your email account.

Medical Record Sharing

As a patient with Springwood Surgery we may need to share your electronic medical record with other local healthcare organisations providing healthcare to you;

☐ YES – Please share my electronic medical record
☐ NO – Do NOT share my electronic medical record

Local healthcare organisations that have cared for you may wish to electronically share their medical information about you with Springwood Surgery;

☐ YES – I consent to Springwood Surgery receiving medical information about me
☐ NO – I do NOT consent to Springwood Surgery receiving medical information about me

Your medical data may also be shared with other health care organisations both regionally and nationally. If you would prefer not to share your medical data please ask a member of our reception team for an 'opt out' form

Medication

Please nominate your preferred pharmacy to assist with the processing of any medication you may require now or in the future;

☐ Boots, Rectory Lane ☐ Boots, High Street ☐ Well, High Street

Springwood Surgery is enrolled within the NHS Electronic Repeat Dispensing System. If you are regularly taking medication and it is appropriate, your repeat prescriptions will be sent electronically to your preferred pharmacy. A member of our reception team or your pharmacist can tell you more about electronic repeat dispensing.

Ethnic Group

☐ White British ☐ White Other ☐ Black Caribbean ☐ Black African
☐ Black Other Mixed ☐ Indian ☐ Pakistani ☐ Bangladeshi
☐ Chinese ☐ Vietnamese

Other ethnic group (*please specify*) ……

Continued overleaf

Carer Details

Are you, or do you have, a carer? ☐ N/A ☐ I am a carer ☐ I have a carer

If applicable, please provide details, including contact details ……

……

Smoking Status

Have you ever smoked? ☐ YES ☐ NO

If YES, are you a; ☐ Current smoker and I currently smoke …….. cigarettes per day
or ☐ Current a user of e-cigarettes
or ☐ Ex-smoker and I used to smoke …….. cigarettes per day

Alcohol Intake

1) How often do you have a drink containing alcohol?

☐ Never ☐ Monthly or less ☐ 2 - 4 times a month

☐ 2 - 3 times a week ☐ 4 or more times a week

2) How many standard drinks containing alcohol do you have on a typical day when drinking (a standard drink is ½ pint of beer, small glass of wine or a pub measure of spirit)

☐ 1 - 2 ☐ 3 or 4 ☐ 5 or 6

☐ 7 - 9 ☐ 10 or more

3) How often do you have 6 or more drinks on one occasion?

☐ Never ☐ Less than monthly ☐ Monthly

☐ Weekly ☐ Daily or almost daily

PLEASE HAND THIS FORM TO A MEMBER OF OUR RECEPTION TEAM WITH YOUR NEW PATIENT REGISTRATION FORM

IF YOU ARE ON ANY REGULAR MEDICATION PLEASE MAKE AN APPOINTMENT TO SEE A DOCTOR AND BRING A LIST OF YOUR CURRENT MEDICATION WITH YOU TO THE APPOINTMENT

IF YOU HAVE A COMMUNICATION NEED AND WOULD LIKE TO RECEIVE INFORMATION IN A DIFFERENT FORMAT TO HELP YOU UNDERSTAND PLEASE INFORM A MEMBER OF OUR RECEPTION TEAM

FOR OFFICE USE ONLY. *This section to be completed by a member of the practice reception team*

☐ GMS1 New Patient Registration form completed by patient and received
☐ Patient informed of allocated GP. Initials of allocated GP ……
☐ GP2GP Information sheet given to patient
☐ Practice Information Leaflet given to patient
☐ New Patient Questionnaire completed by patient and received by …… (staff member initials)