New Patient Questionnaire

Welcome to Paston Surgery

This questionnaire has been designed to help your new GP get to know you and your medical history. The information you provide will be handled confidentially by your GP but if you are concerned about any of the questions please leave them blank. A member of staff will be happy to discuss any queries you have. We will require identification (ID) including photographic ID where possible - see page 4 for documents that are acceptable.

We work to offer high quality family medicine with an accessible friendly approach. We have attached a Practice Leaflet which tells you about the practice, what services we offer and how we work. This includes appointment information and how to obtain repeat medication. Do please read it as it will enable you to get the best from us.

If you have young children at home, please ask the Receptionist for an information sheet for the Health Visitor / School Health Advisor. Please complete this form along with this questionnaire and give it to the Receptionist.

Please be aware that:

- It is important that you have a new patient health check with us.
- We will only prescribe or issue sufficient medication to tide you over until the date of your health check, and no further medication will be prescribed if you fail to attend

You need to have a New Patient Check in order to complete your registration. Please make an appointment at surgery reception to book this with one of the nursing team. If you do not, this will affect the care/medication that we can offer you.

PERSONAL DETAILS:

Title:	Forename:	Surname:	Date of Birth
Home Tel. no:	Mobile Tel no:	Work Tel no:	
Status : Please Circle	Single Married Widowed Divorced Partner Separated		
Occupation :			

Ethnicity — Please tick the box that applies from those listed below

Asian or Asian British

- ☐ Bangladeshi
- ☐ Indian
- ☐ Pakistani
- ☐ Other Asian background

Please State:

Black or Black British

- ☐ African
- ☐ Caribbean
- ☐ Other Black background

Please State:

Mixed

- ☐ White & Asian
- ☐ White and Black African
- ☐ White & Black Caribbean
- ☐ Any other mixed background

Please State:

Other Ethnic Group

- ☐ Chinese
- ☐ Middle Eastern
- ☐ Any other ethnicity

Please State:

White

- ☐ British
- ☐ Irish
- ☐ Any other White background

Please State:

☐ I do not wish to disclose my ethnic origin

First spoken language: _____

Any Significant Health Problems – If yes please give year of diagnosis:-

- ☐ **Atrial Fibrillation**
- ☐ **Absent Spleen (Asplenic)**
- ☐ **Asthma**
- ☐ **COPD (e.g. emphysema or chronic bronchitis)**
- ☐ **Coronary heart disease (e.g. heart failure, myocardial infarction & angina)**
- ☐ **Current kidney disorders**
- ☐ **Depression**
- ☐ **Diabetes**
- ☐ **Epilepsy**
- ☐ **High blood pressure**
- ☐ **Hypothyroidism**
- ☐ **Stroke/CVA/TIA**
- ☐ **Any other significant problem (please detail)**

Medications you are taking now:

If you are currently taking any regular medication, please attach a current medication list from your previous GP to enable us to add to your records with us. If you are unable to provide a printed list you will be required to produce the medication itself. Please note as above you are required to have a new patient check to ensure your medication continues.

Prescription Collections:

Please indicate your preferred medication collection point for repeat prescriptions:

If you live more than one mile from a registered pharmacy, Paston will dispense your prescriptions. Please tick box if this applies ☐

If you live within one mile of the surgery, you can collect your prescriptions from a local pharmacy, please select your preference

Boots ☐ **Well** ☐ **North Walsham Pharmacy** ☐ **Paston Reception** ☐

Allergies:

Please tell us about any allergies you have i.e. drugs or medication e.g. Penicillin, or any other allergies you may have i.e. eggs, animal hair etc:

Smoking Status:

☐ I have never smoked

I am a current smoker, and smoke:

- ☐ Less than 1 per day
- ☐ 1 to 9 per day
- ☐ 10 to 19 per day
- ☐ 20 to 39 per day
- ☐ More than 40 per day

I am an ex-smoker and used to smoke:

- ☐ Less than 1 per day
- ☐ 1 to 9 per day
- ☐ 10 to 19 per day
- ☐ 20 to 39 per day
- ☐ More than 40 per day

Date stopped:_____

If you wish to receive advice or guidance on stopping smoking, please ask at Reception or the Dr / nurse

Female Patients:

Have you ever had a cervical smear? Yes ☐ No ☐

When ? _____ What was the result _____

*Contraception—Do you use the: Pill / Injection / Coil / Condoms / Other? If so what?

_____ Or None? *Please Circle

Carers

Are you a carer for someone who cannot manage without help because of illness / age / disability of any kind?

Yes ☐ No ☐

Name of the person whom you care for? _____

Relationship to you: _____

Are you Cared For?

Do you have a carer because of illness / age / disability of any kind?

Yes ☐ No ☐

Name of the person who cares for you and their contact details? _____

_____

Relationship to you: _____

Power of Attorney

Does someone have Power of Attorney for you OR do you have Power of Attorney for someone?

Yes ☐ No ☐

Name of person who has Power of Attorney for you _____

Name of person who you have Power of Attorney for (if registered at this practice)

_____

If you have any significant health problems please provide details of who we may contact in an emergency:

Name: _____

Telephone No: _____

Relationship to you: _____

Sharing of Patient Medical Records

We are able to Share your records with other sectors of the NHS, that are local to the practice, such as the District Nurse Team, physiotherapy, and smoking cessation, please carefully read, the leaflet that comes with this registration pack. Indicate below if you agree / disagree to this happening and we will then record your choice on your computer medical records, please ensure this form is signed.

Yes ☐ No ☐

Summary Care Records (SCR)

Summary Care Records is not the same as sharing your medical records, SCR means that if you are in any part of the country and need to be seen by a GP or at the hospital you can agree to them seeing some of your medical details, at the moment this would be your name, address, date of birth, NHS number, any current medication you are taking and any allergies. Please make sure that you tick the appropriate box if you agree or not to this information being available and have signed and dated the this form below. We will then record your choice on your computer medical records, please ensure this form is signed.

☐ Yes ☐ No

SMS/Text messaging

We are able to automatically send out text messages to remind you of appointment times and dates. We may also on occasion send texts to you as reminders to book appointments for any on going conditions you may have, such as an annual medication review. Supplying us with your mobile number implies that you wish to receive these messages. If you wish to opt out please tick this box. ☐

Identification for New Registrations

Please be aware that when registering with the surgery we now require new patients to present photo identification (ID) where possible. If photo ID is not available we will accept alternatives.

The list below is the acceptable forms of ID.

A photocopy of the ID presented will be kept until you /families registration has been finalised, after that it will be destroyed:

- Birth Certificate
- Marriage Certificate
- Driving Licence
- Passport
- Local Authority Rent Card
- National Insurance Number Card
- Paid Utility Bill

If you do not have any of the above please speak to reception.

Thank you for completing this form

Your Signature _____ Date _____

If you have completed this form on behalf of another. Please complete the details below

Name _____

Connection/Relationship to patient _____

FOR OFFICE USE ONLY							
Proof of Identity	Passport ☐	Driving Licence ☐	Identity Card ☐	Other ☐			
Proof of Address	Utility Bill ☐	Tenancy Agreement ☐	Bank Statement ☐	Other ☐			