Ibstock & Barlestone Surgeries
Traditional Values, Modern Healthcare

New Patient Questionnaire - Adult

Welcome to Ibstock & Barlestone Surgeries.
*** Please complete a 'New Patient Questionnaire' for <u>each</u> family member (11 years +) ***

Section 1 – Patient Details:

Title:		**First name:**		**Surname:**	

Date of Birth:		**NHS number:** (if known)	

Marital status:		**Occupation:**	

Ethnic Origin: (please tick one)

- ☐ White British
- ☐ White Irish
- ☐ White (Other) ……

- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian
- ☐ Other mixed background ……

- ☐ Caribbean
- ☐ African
- ☐ Black British
- ☐ Black (Other) ……

- ☐ Asian
- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Chinese
- ☐ Asian (Other) ……

- ☐ Other ……

- ☐ Prefer not to say

First Language: ……

Do you require the help of a Translator / Interpreter? (please tick one) Yes / No

Home telephone number:	
Do you consent for the Practice to leave answerphone messages? (please circle one)	Yes / No
Mobile number:	
Do you consent for the Practice to send you SMS (text) messages? (please circle one)	Yes / No
Work number:	
E-mail address:	
Do you consent for the Practice to send you e-mail messages? (please circle one)	Yes / No

If applicable, please provide details of the person(s) who can consent to medical treatment for the patient and has legal responsibility:

Name: ……	**Name:** ……
Relationship: ……	**Relationship:** ……
Contact details: ……	**Contact details:** ……

Next Of Kin:		**Relationship:**	
Contact details:			

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Do you have a carer? (please circle one)	Yes / No
If yes, please provide the following information: **Name:** ……..…… **Contact details:** ……	
Do you consent to your information being shared with your Carer?	Yes / No

Are you a carer? (please circle one)	Yes / No
If yes, are they a patient of this Practice? (please circle one) **Please provide their name:** ……	Yes / No

Are you currently a member of the Armed Forces? (please circle one)	Yes / No
Are you a Military Veteran? (please circle one) **If yes, please specify:** ……..……	Yes / No

Section 2 – Family History and Allergies / Sensitivities / Intolerances

Have any of your immediate relatives had any of the following?
If yes, please specify the following: type of diagnosis, their relationship to you and the age they were diagnosed.

- ☐ Blood disorder ……
- ☐ Heart condition ……
- ☐ Heart Attack ……
- ☐ Cancer ……
- ☐ Diabetes ……
- ☐ High cholesterol ……
- ☐ Glaucoma ……
- ☐ Deep Vein Thrombosis (DVT) ……
- ☐ Epilepsy ……
- ☐ Kidney Disease ……
- ☐ Mental Health problem ……
- ☐ Asthma ……
- ☐ Respiratory condition ……
- ☐ Stroke / Transient Ischaemic Attack (TIA) ……
- ☐ Other (please specify) ……

Do you have any allergies / sensitivities / intolerances that you know of? (including medications, dressings etc.) **If yes, please specify:** ……..… ……	Yes / No

Are you taking any current medication? **If yes, please specify:** …….. …… *If you are, please ensure you have **1 month's supply of medication** from your current GP Practice before registering.*	Yes / No

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Section 3 – Lifestyle

Height: (m)		**Weight:** (kg)	

Alcohol screening (FAST-C)

☐ **Please tick this box if you do not wish to complete this questionnaire.**

Questions	**Scoring system**					**Your score**
	0	**1**	**2**	**3**	**4**	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
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	

Alcohol screening (AUDIT-C)

☐ **Please tick this box if you do not wish to complete this questionnaire.**

Questions	**Scoring system**					**Your score**
	0	**1**	**2**	**3**	**4**	
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 the last year	
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	

*If you score more than **8** on the FAST-C and AUDIT-C questionnaires combined you will be contacted by a member of the clinical team to discuss your results.*

☐ **Please tick this box if you do not wish to be contacted.**

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Smoking status: (please tick one) **If you're a smoker please specify your daily tobacco consumption:** …….. *If you are interested in stopping, you can contact the Stop Smoking Service Quit51 on 0800 6226968.*	☐ Smoker ☐ Ex-smoker ☐ Never smoked

How often do you exercise a week? (please tick one) **Please specify the type of exercise you do:** ……..……..……..……	☐ Zero times a week ☐ Once a week ☐ Twice a week ☐ Three times a week ☐ Four times a week ☐ Five times a week or more

Section 4 – Specific Needs

Do you have any sensory impairment? (i.e. speech, hearing, sight) (please circle one) **If yes, please specify:** ……..……..……..……..……	Yes / No

Are you an 'Assistance Dog' user?	Yes / No

Do you have any physical disabilities that may prevent you from accessing the Practice premises? **If yes, please specify:** ……..……..……..……..……	Yes / No

Do you have a named Social Worker? (please circle one)	Yes / No
If yes, please provide the following information: **Name:** ……..…… **Contact details:** ……..……	

Have you nominated a Power of Attorney? (please circle one)	Yes / No
If yes, please provide the following information: **Name:** ……..…… **Relationship:** ……..…… **Contact details:** ……..…… **Address:** ……..……	

Section 5 – Your Named Accountable GP and the Patient Participation Group (PPG)

Under the terms of the latest GP Contract, all patients must have a Named Accountable GP. Having a Named Accountable GP does not prevent you from seeing any other GP in the Practice. If you're Named Accountable GP is unavailable and you require urgent medical attention you may need to discuss this with another GP. Please note that your medical records are available to all the GPs in the Practice. Should you wish to change your Named Accountable GP; the Practice will make reasonable efforts to accommodate this request.	Your Named Accountable GP is: **Dr C Luke**

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At Ibstock & Barlestone Surgeries we have an agreement with Community Health Services that incorporates a Children's Health Visiting and School Nursing Liaison service, whereby a Health Visitor is allocated and based at the Practice. The Health Visitor's contact details are below: **Base:** Ibstock Surgery **Telephone number:** 01530 264 928 The School Nursing Services' details are below: **Base:** Ashby Hospital **Telephone number:** 01530 566911	Our Health Visitor is: **Helen Stamp**

Patient Participation Group (PPG)

The Practice is committed to improving the services we provide to our patients. It is vital that we hear from patients to understand their views, ideas and learn from previous experiences. This enables us to review current processes and where possible implement change to improve patient care.
Should you wish to become involved in the PPG, you would be helping us to plan the future of the Practice and be informed of opportunities to give your views and keep up to date with developments within the Practice.

Would you like to become a member of the PPG? (please circle one) *If you have ticked yes, we will arrange for a PPG Application Form to be given to you.*	Yes / No

If you are completing this form for yourself please complete Section 1.
If you are completing this form on behalf of another person or child, please complete Section 2.

Section 1 – Patient Details

Patient Signature:	
Date:	

Section 2 – Your Details

Your name:	
Relationship to patient:	
Your Signature:	
Date:	

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Summary Care Record Consent Form

Summary Care Record Consent Options:

Consent (please tick one)

☐ I consent for my medications, allergies and adverse reactions to be included in my Summary Care Record

OR

☐ I consent for my medications, allergies and adverse reactions AND additional information to be included in my Summary Care Record

Dissent

☐ I DO NOT wish to have a Summary Care Record

Patient Details:

Title:		**First name:**		**Surname:**	

Address:	

Date of Birth:	

If you are completing this form for yourself please complete Part 1.
If you are completing this form on behalf of another person or child, please complete Part 2.

Part 1 – Patient Signature:

Patient Signature:	
Date:	

Part 2 – Your Signature:

Your name:	
Relationship to patient:	
Your Signature:	
Date:	

Please see overleaf for information regarding the Summary Care Record.

Summary Care Record (SCR)

What is a Summary Care Record (SCR)?

The Summary Care Record is a 'short summary' of your GP medical record which includes:

- medications;
- allergies;
- adverse reactions.

This is automatically generated when you register at a GP Practice.

Why do I need a Summary Care Record (SCR)?

As well as at your GP Practice, the Summary Care Record can be used by other NHS organisations such as A&E, Out of Hours / NHS 111 and Pharmacies.
Due to these organisations not having access to your full GP medical record, being able to view your SCR may enable them to treat you more efficiently.

Consent to sharing my Summary Care Record (SCR).

Other NHS organisations will ask for your consent before viewing your SCR. In an emergency, if you are unable to provide consent, for example if you were unconscious, your SCR can still be viewed but only by health and care staff with the right levels of security clearance, so your information is secure.

<u>SCR – Additional Information:</u>
You can also consent to including 'additional information' into your SCR which includes:

- diagnoses;
- current problems and issues;
- vaccinations;
- consent and personal preferences;
- details of your care professionals / carers;
- care plan events;
- social and personal circumstances.

If you wish to have an SCR, with or without the additional information, you can 'consent' by completing the form overleaf.

Dissent to sharing my Summary Care Record (SCR).

If you do not wish for your SCR to be shared with other NHS organisations, you can 'opt out' by completing the form overleaf.

What does it mean if I do not have a Summary Care Record (SCR)?

NHS health and care staff caring for you may not be aware of your medications, allergies and adverse reactions in order to treat you safely.

If you have any queries regarding your Summary Care Record, please do not hesitate to ask us.