The Beeches Medical Centre, Liverpool Road, Longton, PR4 5AB
Telephone: 01772 285 540; Email: lscicb-csr.thebeeches@nhs.net

NEW PATIENT QUESTIONNAIRE

The information that we are seeking on this form is to help us offer you the best advice and treatment that we can. All the information you provide in this questionnaire is strictly confidential and will become part of your medical record. Please tell us as much as you can and return this form to the surgery together with the registration form and documents to verify your identity.

ABOUT YOU

Title		Surname	
Forename(s)		Date of Birth	
Occupation		Home phone number	
Mobile phone number		Email address	

Marital status (Circle as appropriate)	Married or Civil Partnership	Widowed	Divorced or Separated	Single

COMMUNICATIONS

Do you have any additional communication needs? YES / NO

If yes to the above, please explain what needs you have so that the surgery can best accommodate you.

We now use a variety of methods to communicate with our patients.

(Please delete as appropriate)

I consent to the practice sending SMS messages: YES / NO

I consent to the practice sending emails: YES / NO

We offer online access to patients for booking appointments and ordering repeat medication. Please indicate if you would like to sign up for this service.

Yes, I would like online access: □ No, I do not require online access: □

WHAT IS YOUR ETHNIC GROUP?

(Please circle as appropriate)

White British	White Irish	Other White background	
Mixed White + Black Caribbean	Mixed White + Black African	Mixed White + Asian	Other Mixed background
Indian	Pakistani	Bangladeshi	Other Asian background
Caribbean	African	Other Black background	
Chinese	Other Ethnic group		Prefer Not To Say

REPEAT MEDICATION

Please list all tablets, medicines, creams, or injections that are prescribed for you on a regular basis.

(If possible, please attach a repeat prescription slip from your previous GP surgery)

Name of drug	**Strength**	**How often & when do you take it**

SMOKING STATUS

Do you smoke?	Yes /No	Have you ever smoked?	Yes /No

If you are an ex-smoker:

When did you stop? (approx. month/year)		How much did you smoke before giving up?	

If you are a current smoker:

What do you smoke?	Cigarettes / cigars / pipe / E-Cigarette	How much do you currently smoke?	
Would you like help to stop smoking	Yes / No		

ALLERGIES

Do you have any allergies? YES / NO

If YES, please give further details:

ALLERGY	REACTION

ALCOHOL CONSUMPTION

Alcohol use can affect your health and can interfere with certain medications and treatments. Your answers will remain confidential so please be honest.

Pint of regular Beer / Lager / Cider or glass of wine (175ml)	2 units	Alcopop or can of lager	1.5 units
Single measure of spirits	1 unit	Bottle of wine	9 units

Questions	**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 question 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	

Your total score	

CARERS AND THE CARED FOR

Are you a Carer?	Yes / No
Does someone care for you?	Yes / No
If you are cared for, please state your carers address and your relationship with them	

If someone else cares for you, it is important for us to hold this information in your medical record, please sign below if you wish us to disclose information about your health to your carer.

Signature	

NEXT OF KIN

Name: _____

Relationship to Patient: _____

Contact Number: _____

SHARING YOUR RECORD

Patient Consent From

We recognise the importance of protecting personal and confidential information in all that we do, and we will take care to meet our legal duties, as the law determines how organisations can use the personal information that we collect.

To support our statutory obligations, we must inform you of who we will share information with and allow you to determine whether you wish us to share the information that we have recorded about you within your patient record. You have the right to withdraw consent at any time and to change who you wish us to share your information with. Should this be the case, we will inform the relevant partner organisations and advise them of your decision.

I, …… (Print Name), give/does not give (delete as appropriate) consent for my information to be shared to discuss the care that is provided to identify services and resources which could support my health and wellbeing.

For further information on who we share with and what steps we take to protect the information we hold, please speak to any member of the Practice team.

Please tick against each data set identifying if you wish/do not wish to share data

Record sharing initiative	I hereby give consent for my information to be shared	I do not consent for my information to be shared
Summary Care Record		
Care Data		
Local Shared Care Record (Local providers only)		

NAMED GP

The Government requires that all patients have a named GP who will have overall responsibility for the care and support that our surgery provides. **DR GIGURAWA WIJETHILLEKE** will be your named GP however, this does not prevent you from seeing any GP in the practice.

For Staff Use Only

Please ensure that the referring organisation is removed from the list of options above.

Ensure that a copy is provided to the patient, stored in the paper medical record and shared with the appropriate organisations.

Should the above-named patient indicate that they wish to amend the organisations that they have consented to share with or that they have withdrawn consent completely, please ensure that a new form is completed with the revised choices and then share and store as previous.

Code **9Nu0** entered in patient's record (Dissent from secondary use of GP patient identifiable data)	Initials
Code **9Nu4** entered in patient's record (Dissent from disclosure of personal confidential data by Health and Social Care Information Centre)	Initials