



## New Patient Questionnaire

Welcome to our medical practice. In order to ensure that we know enough about you to complete your registration and best support your health care needs, please take a few minutes to complete this questionnaire - all your information will of course be kept confidential.

### Some important information about you (or the person you are registering)

Mr   
  Mrs   
  Miss   
  Dr   
  Other   

First Name(s)       Surname

Address   
  
 Postcode       Date of Birth  /  /

Nationality       Mobile

Occupation       May we send you text messages?     Y     N

Religion       Telephone






Email

May we send you emails about your care?     Y     N

### Your communication needs

Main spoken language

If you have any specific communication needs, please tell us how we should best communicate with you

 Braille   
   Large type   
   Audio   
   Easy Read   
   Other, please tell us what

### Supporting carers

A carer is anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support. Anyone can become a carer; carers come from all walks of life, all cultures and can be any age.

Are you a carer?     Y     N      Do you have an unpaid carer?     Y     N

What is their name and relationship to you?

If you are a carer, would you like to be contacted with support information?     Y     N

If you have a carer, are you happy for us to contact them?     Y     N



## Application for online access to your medical record

I wish to have access to the following online service (✓ all that apply)

Booking appointments     Requesting repeat prescriptions     View my coded medical record

I wish to access my medical record online and,

- I have read and understood the information leaflet provided to me by the Practice
- I accept responsibility for the security of any information that I see and / or download
- I will contact the Practice as soon as possible if I suspect that my account has been accessed by anyone without my agreement
- If I see information in my record that is not about me or I believe to be inaccurate, I will contact the Practice as soon as possible
- If I feel that I may come under pressure to give access to my account unwillingly to someone else, then I will contact the Practice as soon as possible

## About your health and lifestyle

Do you have any **allergies**?     Y     N    If yes, please give details

Do you **exercise** regularly?     Y     N    If yes, please give details

Your weight  Kg / St.    Your height  cm / Ft.    Are you happy with your weight?     Y     N

## Smoking

Please ✓ the most appropriate option

Smoker    Number of cigarettes  per day

Ex-smoker    When did you quit

Never smoked

## Family Medical History

Has any member of your immediate family (parents, grandparents, siblings or children) had any of the following? Please **circle** any that apply.

♦Angina ♦Arthritis ♦Asthma ♦Cancer ♦Chronic Bronchitis ♦Diabetes ♦Depression or Mental Illness ♦Disability (mental / physical) ♦Eczema ♦Epilepsy ♦Glaucoma ♦Hay fever ♦Heart Attack ♦Hearing Difficulty ♦High Blood Pressure ♦Hysterectomy ♦Migraine ♦Poor Eyesight ♦Stroke ♦Thyroid Disease ♦Tuberculosis ♦Ulcer

Yes     No     If yes, please give details

## Alcohol

How often do you drink alcohol?

Never     2-4 times a month

Monthly or less     2-3 times a week

4 or more times a week

How many standard alcoholic drinks do you drink on days when you are drinking?

1-2     3-4     5-6     7-9

10 or more

How often have you had 6 or more drinks on one occasion?

Never     Less than monthly

Monthly     Weekly

Daily or almost daily

## Declaration

I confirm that the information provided is accurate and true to the best of my knowledge

Signed     Date

If you are signing on behalf of the patient, please print your name and relationship to the patient here

## For Practice Use Only

NHS Number  -  -

ID Verified by     Date  /  /

Vouching     Info in record     Photo ID & proof of address

Authorised by     Date  /  /

Acc. Created  /     Passphrase sent

**Existing patients requesting access to online services need to complete their name, address, date of birth, online services application and declaration only.**

*Coded record access only to be granted*