JOHN TASKER HOUSE & FELSTED SURGERIES

NEW PATIENT QUESTIONNAIRE

YOU ARE REQUIRED TO PROVIDE SUITABLE PROOF OF RESIDENCE (I.E. UTILITY BILL OR DRIVING LICENCE) WITH YOUR COMPLETED REGISTRATION FORM.

1) **PATIENT DETAILS:** ***(please use CAPITAL LETTERS)***

FULL NAME: _____ **DATE OF BIRTH dd/mm/yyyy:** _____

CONTACT TEL NO: _____ **EMAIL:** _____

2) **ETHNICITY**: British ☐ Mixed British ☐ Other (Please state) _____

Main language (*if not English*)
Which is your main language? _____ Do you speak English? Yes ☐ / No ☐
If no, do you need a translator? Yes ☐ / No ☐

3) **SMOKING STATUS**
Do you smoke? Yes ☐ / No ☐ If yes, how many cigarettes do you smoke daily? _____
If no, have you smoked in the past? Yes ☐ / No ☐ Do you use electronic cigarettes? Yes ☐

4) **HEIGHT/WEIGHT** **What is your weight:** _____ kg/stone **Height:** _____cm/feet & inches

5) **ALCOHOL INTAKE**
Teetotaller ☐

One unit of alcohol

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink that contains alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many alcoholic drinks do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

6) **CARER STATUS**
Are you a Carer? ☐ Do you have a Carer? ☐ Name of Carer: _____

7) **NEXT OF KIN(S)** Name & Relationship: _____

Contact Telephone(s): _____

8) **CONTACTING YOU:** We will use your contact details to send reminders about appointment, reviews and other services which may be of benefit in your medical care. ***Do you consent for the surgery to send:***
Letters to your home address Yes ☐ / No ☐ **Text messages to your mobile** Yes ☐ / No ☐

9) **SUMMARY CARE RECORD (SCR)**

For more information: Phone 0300 123 3020 or visit www.nhscarerecords.nhs.uk
All patients registered with a GP have a SCR, unless they have chosen not to have one. Your Summary Care Record contains basic information about allergies, medications, and any reactions that you have had to medication in the past. ***Go to our website JTH.org.uk for full information.***

A. I would like to include additional information in my SCR ☐

Does anybody hold Lasting Power of Attorney for Health & welfare for you? Yes ☐

If "Yes" to either of the above, please supply details of who/where it is kept and provide a copy(ies) for your medical notes: _____

11) DISABILITIES / ACCESSIBLE INFORMATION STANDARDS (*if yes, please state*)

Do you have any special communication needs? Yes ☐ _____

Housebound ☐ **Blind/partially sighted?** ☐ **Hearing problems** ☐

12) FAMILY HISTORY AND PAST MEDICAL HISTORY:

Condition	✔	Relationship	Condition	✔	Relationship
Heart Attack/Angina – under 60	☐		Asthma	☐	
Heart Attack/Angina – over 60	☐		Epilepsy	☐	
Stroke	☐		Cancer	☐	
Diabetes	☐		Rheumatoid Arthritis	☐	
High Blood Pressure	☐				

13) Have you ever suffered from any significant medical illness, operation, or admission to hospital. If so please enter details below:

Condition	Year	Ongoing	Condition	Year	Ongoing
		☐			☐
		☐			☐

14) ALLERGIES: Please list any drug or food allergies that you knowingly have:

_____

15) MEDICATION: If you require REPEAT medication(s), please provide the prescription repeat medication slips; medication boxes showing your details so that this can be input onto your records.

16) PRACTICE CHARTER

At our surgery we aim to provide our patients with the best quality care available. Our charter is a statement of what you can expect from this practice and what we feel we can expect in return from you.

We will: treat you with respect and as an individual; maintain confidentially; aim to respond to your needs efficiently and appropriately; keep you informed of any changes that may affect you; encourage comments and suggestions to help continually improve services.

We Ask that you: treat us with respect; keep us informed of any changes that may affect us; share responsibility for your own health.

Our Values: patients come first; we have a positive attitude and response to any challenges; we provide continuity of care; we take responsibility and are accountable; we promote excellence through teaching and research; we continually improve; we balance individuals needs with wide clinical needs.

ZERO TOLERANCE: If a patient is violent or abusive towards any member of the practice team, we shall remove them from our list in accordance with NHS policy.

Complaints: We will respond to any complaints fairly and efficiently according to the NHS complaints procedure.

Signature: _____ **Name:** _____

(if signing on behalf of patient, please state relationship) _____

17) NHS APP (ONLINE PATIENT ACCESS): We encourage patients to use online services via the NHS App to:

- ○ **Book & cancel appointments**
- ○ **Order repeat prescriptions**
- ○ **View your medical record**

PROXY ACCESS:

If you feel it is necessary to permit Proxy to a trusted person, to allow access to your records (i.e. to order medication on your behalf). You will be asked to complete a form which will then be passed to a GP to assess your status and authorise accordingly.