Haddenham Medical Centre – New Patient Questionnaire

Welcome to Haddenham Medical Centre. Please complete the following information; this will enable us to update your medical history on our clinical system.

Data input on this form will be input into your health record. I consent to this data being input into my health records – PLEASE SIGN ……..

Your usual Dr is: ……..., however you may choose to see any other available Dr.

You may register for online services which will enable you to book appointments, order repeat prescriptions and view elements of your medical record. Please ask at reception.

DO YOU HAVE ANY SPECIAL COMMUNICATION NEEDS? YES / NO
(If Yes, please ask reception for a communication form)

<table>
<tr><td colspan="2">SURNAME:</td><td colspan="2">FORENAMES:</td></tr>
<tr><td colspan="4">ADDRESS including POSTCODE:</td></tr>
<tr><td colspan="2">HOME TELEPHONE:</td><td colspan="2">MOBILE TELEPHONE:</td></tr>
<tr><td colspan="4">I consent to receiving SMS text message reminders for appointments and other health information relating to my care - PLEASE SIGN ……</td></tr>
<tr><td colspan="2">RELIGION:</td><td colspan="2">OCCUPATION:</td></tr>
<tr><td colspan="2">MARITAL STATUS:
single /married /divorced /separated /
widowed /co-habiting /civil partnership</td><td colspan="2">DATE OF BIRTH:</td></tr>
<tr><td colspan="4">Sexual Orientation: Which of the following options best describes you?
□Heterosexual/Straight □Lesbian/Gay □Bisexual
Which of the following best describes how you think of yourself?
□Female (including trans women) □Male (including trans men)
□Non-binary □In another way
Is your gender identity the same as the gender you were given at birth? Yes/No</td></tr>
<tr><td colspan="2">ETHNIC ORIGIN
White
□ British
□ Irish
□ Other(specify)
Black or Black British
□ African
□ Caribbean
□ Other(specify)
Asian or Asian British
□ Bangladeshi
□ Indian
□ Pakistani
□ Other(specify)
Chinese
□ Chinese
□ Other(specify)</td><td colspan="2">ETHNIC ORIGIN
Mixed
□ White and Asian
□ White and Black African
□ White and Black Caribbean
□ Other(specify)

Any other ethnic group
□ Specify

□ Decline to give ethnic origin

Main language Spoken:

□ Decline to give main language spoken</td></tr>
</table>

LIFESTYLE: SMOKING

Do you currently smoke?

☐ Yes, I currently smoke

____ cigarettes / day

____ cigars / day

pipe

☐ No, but I used to smoke regularly. I stopped smoking in ____ (year)

☐ No, I have never been a smoker

LIFESTYLE: ALCOHOL

please circle your answers

1. How often do you have a drink containing alcohol?

Never	Monthly or less	Two to four times a month	Two to three times per week	Four or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

1 or 2	3 or 4	5 or 6	7 to 9	10 or more

3. How often do you have six or more drinks on one occasion?

Never	Less than monthly	Monthly	Two to three times per week	Four or more times a week

Questions					
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 you cut down?	No		Yes, but not in the last year		Yes, during the last year

LIFESTYLE: PHYSICAL ACTIVITY QUESTIONNAIRE:

1. Please tell us the type and amount of physical activity involved in your work

		Please mark one box only
A	I am not in employment (e.g. retired, retired for health reasons, unemployed, fulltime carer etc.)	
B	I spend most of my time at work sitting (such as in an office)	
C	I spend most of my time at work standing or walking. However, my work does not require much intense physical effort (e.g. shop assistant, hairdresser, security guard, childminder, etc.)	
D	My work involves definite physical effort including handling of heavy objects and use of tools (e.g. plumber, electrician, carpenter, cleaner, hospital nurse, gardener, postal delivery workers etc.)	
E	My work involves vigorous physical activity including handling of very heavy objects (e.g. scaffolder, construction worker, refuse collector, etc.)	

2. During the *last week* , how many hours did you spend on each of the following activities? *Please answer whether you are in employment or not*

Please mark one box only on each row

		None	Some but less than 1 hour	1 hour but less than 3 hours	3 hours or more
A	Physical exercise such as swimming, jogging, aerobics, football, tennis, gym workout etc.				
B	Cycling, including cycling to work and during leisure time				
C	Walking, including walking to work, shopping, for pleasure etc.				
D	Housework/Childcare				
E	Gardening/DIY				

3. How would you describe your usual walking pace? Please mark one box only.

Slow pace (i.e. less than 3 mph)		Brisk pace	
Steady average pace		Fast pace (i.e. over 4mph)	

LIFESTYLE: DIET

Is there anything special or unusual about your diet?

LIFESTYLE: OTHER DRUGS

Do you misuse or have you ever misused other drugs or solvents?

If you are returning from the Armed Forces

Address before enlisting:

Which Service were you in?

Service/Personnel number:

Do you have any medical issues caused by your service?

Please ask Reception for a Veterans Info pack.

MEDICATION:
If you are on regular medication, please arrange to see a doctor to have this checked and prescribed. Please bring an old repeat prescription list.

What drug or medicine?	What is it for?

Electronic Prescription Service (EPS2) – Pharmacy Nomination (see leaflet)

I wish my prescriptions to be sent to:-

I am already registered at a pharmacy – please state where:-

MEDICINE OR DRUG ALLERGY:

What drug or medicine?	What happens if you use it?

DO YOU HAVE A CARER?
Name and address:

DO YOU CONSENT FOR US TO CONTACT YOUR CARER ABOUT YOU?
PLEASE ASK RECEPTION FOR A PATIENT CONSENT FORM.
Yes/No

ARE YOU A CARER? DO YOU LOOK AFTER A FRIEND, FAMILY MEMBER OR NEIGHBOUR, WHO CANNOT MANAGE WITHOUT YOU? WE CAN SUPPORT YOU – PLEASE SPEAK TO RECEPTION FOR A CARERS PACK
Name and address:

NEXT OF KIN…

Name: **Relationship:**

Contact number:

For patients <u>aged 85 or over</u>: (these are to help us assess if you need additional clinical input)

In general, do you have any health problems that require you to limit your activities?

In general, do you have any health problems that require you to stay at home?

Do you regularly use a stick, walker or wheelchair to get about?

In case of need, can you count on someone close to you?

Do you need someone to help you on a regular basis?

Please provide details, if the person is different from the information you have provided as your carer.

FAMILY HISTORY:
Have any relations had any of the following:

Problem	Relative	Problem	Relative
Heart disease		Stroke	
Diabetes		High blood pressure	
Epilepsy or fits		Cancer (specify type)	

LAST CERVICAL SMEAR When? Where? Result?	**MAMMOGRAM** Have you ever had mammogram or other breast cancer screening? What and when?

Contraceptive Services:

Coil fittings/removal appointments are available. Patients will need to discuss with Dr ……. before an appointment is made. Please be aware there may be a waiting list for the appointment.

Patient options for GP data sharing

In accordance with the Data Protection Act 2018 you have the right to know how your data is being used and to control how your personal information is shared. Please read through the information below to understand the ways in which your data can be shared and then complete the form overleaf to indicate your preferences for each of the following data sharing options:

Summary Care Record (SCR) and My Care Record

Summary Care Record (SCR)

The NHS in England is using a national electronic record called the Summary Care Record (SCR) to support patient care. The Summary Care Record is a copy of key information from your GP record. It provides authorised healthcare staff with faster, secure access to essential information about you when you need unplanned care or when your GP practice is closed. Summary Care Records improve the safety and quality of your care.

Local sharing via My Care Record

Your patient record is held securely and confidentially on the electronic system at your GP practice.

If you require attention from a health and social care professional such as an Emergency Department, Minor Injury Unit, social worker, or Out Of Hours location, those treating you would be better able to give you appropriate care if some of the information from the GP practice was available to them. This information can now be shared electronically via My Care Record.

In all cases, the information will be used only by authorised health and social care professionals involved in your direct care. Your permission will be asked before the information is accessed, unless the health and social care user is unable to ask you and there is a clinical reason for access, which will then be logged.

National Data Opt-Out

NHS has launched a new facility for individuals to opt-out from the use of their data for research or planning purposes. To find out more please visit: www.nhs.uk/you-nhs-data-matters, you can manage your choices online.

Patient details (please write in CAPITAL LETTERS)			
Title:		**Forenames**:	
Surname/Family name:			
Address:			
Postcode:			
Home phone number:			
Mobile phone number:			
Email address:			
Date of birth:		**NHS number (if known):**	
Signature:		**Date:**	
If the person signing above is not the patient, please also enter the signatory's name and relationship to the patient, e.g. parent, guardian, attorney			
Full name:			

Please circle your sharing preferences below.
Once complete please return this form to your GP practice.

1.	**The Summary Care Record (SCR)** Used nationally across England	YES 9Ndm	NO 9Ndo
2.	**My Care Record** Used locally across Buckinghamshire and the immediate surrounding area	YES 93C0	NO 93C1

Thank you!