Retford Primary Care Centre
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ID Checked ☐ Type of ID……………………………………

New Patient Health Questionnaire

Welcome to Crown House Surgery.

There is often a delay with the receipt of your medical records. To enable us to give you correct medical care until these records arrive, please complete the following questionnaire.

PLEASE NOTE: The information you write down will be in the strictest confidence and only for the use of Crown House Surgery. We take our patients confidentiality extremely seriously.

Full Name: ………………………………………………… Date of Birth: …………………..

* Ethnic Origin

Please tick one box that most reflects your background:

White British ☐	Indian ☐	Black African ☐
Black British ☐	Pakistani ☐	Other Black Ethnic Group ☐
White Irish ☐	Bangladeshi ☐	Black - other, mixed ☐
Irish Traveller☐	Chinese ☐	Other Ethnic Group ☐
Polish ☐	Other Asian ☐	Black Caribbean ☐
Turkish ☐	Bangladeshi ☐	Other Please state: ………………….

All service veterans should receive priority access to NHS care for any condition which is likely to relate to their military service. Therefore we would like to know if you are you an ex-service man/woman? YES/NO

* Main Spoken Language………………………….

* Occupation………………………………….

* Next of Kin…………………………………..

Personal Medical History

Height: …………………………Feet/inches OR ……..………………………. cm

Weight: ……………………….. Stones/lbs OR …………………………….....kg

Do you suffer from any of the following conditions? (please tick)

Diabetes, Type I / II ☐	Stroke ☐	Epilepsy ☐
Heart Problems ☐	Cancer ☐	Tuberculosis ☐
Thyroid problems ☐	Asthma ☐	Depression ☐
High Blood Pressure ☐	Arthritis ☐	Stomach ulcer ☐
COPD/Emphysema or Chronic Bronchitis ☐	Other (please state): ………………………………………. ………………………………………………………	

Please list below any history of illnesses, operations or disabilities and the date of occurrence:

Details	Date

Do you have any allergies? If so please list below:

Medication

Please list any medications you are currently taking, or provide your order form from your previous GP

(1)	(3)	(5)
(2)	(4)	(6)
(7)	(8)	(9)

* Family Medical history

Have any close relative (mother, father, sister, brother) suffered from any of the following?
Please note down their relationship to you

Diabetes ☐……………………
Stroke ☐……………………
Heart Attack <60yrs ☐……………………
Asthma ☐ ……………………
Blood pressure ☐ ……………………
Cancer ☐ ……………………

*Are you adopted: Yes ☐ No ☐

Lifestyle

*** Smoking**

Do you smoke? Yes/No
Are you an ex-smoker? Yes / No
Please specify:
Cigarettes ☐ …….. amount per day Cigars ☐ …….. amount per day Pipe ☐ ……..g per day

If you are a current smoker, would you like help to stop smoking? Yes ☐ No ☐

*** Diet**

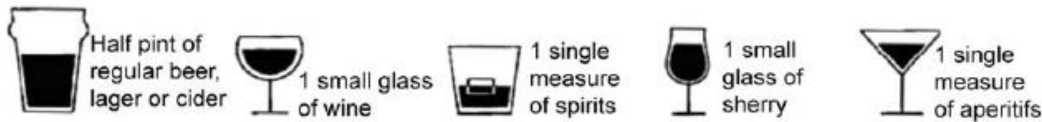
Normal diet ☐
Diabetic diet ☐
Weight reducing diet ☐
Low fat diet ☐
Low sodium diet ☐
Lipid-lowering diet ☐
Vegetarian diet ☐
Vegan diet ☐

*** Alcohol**

How many units of alcohol do you consume per week? ………………/units per week

Please complete the following questionnaire (3 questions):

This is one unit of alcohol…



…and each of these is more than one unit

AUDIT – C

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	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

If your score was **5 or greater** please complete the questionnaire on the next page, otherwise please move on to the next section

Score from AUDIT- C

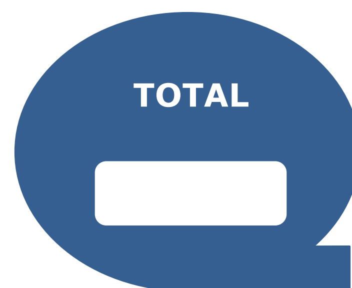
Only complete this section if you scored 5 or greater on the previous page

Remaining AUDIT questions

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	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 Higher risk, 20+ Possible dependence

TOTAL Score equals
AUDIT C Score (above) +
Score of remaining questions



If your score form this section is **8 or greater**, you will be advised to complete a depression screening questionnaire & to see a GP or our Advanced Nurse Practitioner.

All information is held in the strictest confidence.

* Carers

Do you care for a member of your family or a friend? Yes / No
If yes please ask for a Carer Registration Form.

Does a member of your family or a friend care for you? Yes / No
If yes please ask for a Carer Registration Form.

If you are a Carer or you have a Carer do you receive any support from Social Services? Yes / No
If NO would you like some information?

* Communication

Do you have any communication or information needs? Yes / No
(Different format of letters, e-mail or telephone communication only etc.)

If yes, please specify:……………………………………………………………………………………….

………

FOR WOMEN ONLY

Pregnancy
Have you ever been pregnant? Yes/No If Yes, how many times? ………………

Have you had any problems during pregnancy? (please give details)…………………………….
………………………………………………………………………………………………………..

Contraception
Are you currently using any contraception? Yes/No
Please state
- Contraceptive Pill ☐
- Implant ☐ Date fitted:………………..
- Coil ☐ Date fitted:………………..
- Depo-Provera Injection ☐

Screening
* Have you had a cervical smear? Yes/No If Yes: When was it taken? ……………………
What was the result? ………………….

Have you ever had a mammogram? Yes/No
Do you practice breast self-examination? Yes/No

Electronic Prescribing Service (EPS)

You can have your prescriptions sent to a Pharmacy or appliance contractor electronically.

What does this mean for you?

- Have more choice about where to get your medicine from, a Pharmacy near where you work or shop
- You will not need to collect your paper prescription from us, just collect directly from the Pharmacy

Is the service right for you?

Yes, if you have:

- A stable condition
- You don't want to visit your GP Surgery every time to collect a paper prescription
- You want to collect you medication from the same time, most of the time.

No, if you have:

- Any controlled drugs in your prescription (these are unable to be sent electronically at the moment)

What you need to do:

- Contact your chosen Pharmacy, they will then set your nomination

Can I change my nomination or cancel it to receive a paper prescription?

- Yes, you can cancel ir or change your nominated Pharmacy to someone else at ANY time, either by the Pharmacy or by the GP Surgery.

Is the service reliable, secure & confidential?

- Yes, your electronic prescription will only be seen by the same people that saw your paper prescription.

Sharing Information with Emergency Care Services

The Summary Care Record (SCR) consists of the following information about you:
Name
Date of birth
Address
Registered GP
Medication
Allergies
Adverse Reactions

The SCR is only used by Hospital emergency services or other GP Practices across the country should you register temporarily whilst on away from home or holiday etc.

For more information talk to our practice staff, visit the website or **www.nhscarerecords.nhs.uk** or telephone the dedicated NHS Summary Care Record Information Line on 0300 123 3020.

Please tick here if you **do not** want a SCR ☐

Patient Name:…………………………………………………..

Signed:…………………………… **Date:…………………….**

Signed on behalf of patient:…………………………… **Relationship:…………………….**