HOLBROOK AND SHOTLEY SURGERY - NEW PATIENT QUESTIONNAIRE

Name ………………………………………….….…. Date of Birth ……/……/……

Home Tel …………………………………. Mobile …………………………………

Email ……………………………………………………………………………………………

Preferred method of contact: letter / text / email (please circle)

Religion ………………………………… Ethnicity …………………………….

First Language ………………… English Speaking **YES/NO**

NEXT OF KIN DETAILS

Full Name ……………………..……… Relationship …………………… Tel ………………………………

Address ……………………………………………………………………………………………

Do you have any allergies / special needs/ disabilities?

If yes please specify……………………………………………………………………………….

REPEAT MEDICATION REQUIRED YES/NO Details **……………………………………**

Please note that if you are on any repeat medication, you will need to see a GP with your previous medication list, before you need your next prescription. Please indicate by ticking a box below which surgery you would prefer to collect your prescription from.

☐ Holbrook ☐ Shotley

FAMILY HISTORY (immediate family only)

Any important family illnesses or diagnoses
……

ALCOHOL STATUS

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	

SMOKING STATUS

Smoker **YES/NO** How many per day? …. Ex-Smoker **YES/NO**

If you are a smoker would you like smoking cessation advice **YES/NO**

CARERS

Do you have a carer? **YES/NO** If yes please provide details ……

Are you a carer? **YES/NO** If yes please provide details ……

SPECIFIC NEEDS

Have you nominated someone to speak on your behalf? eg: Power of Attorney **YES/NO**

If yes please provide details and copy of POA/Letter of Authority ……

If you were previously in the Armed Forces, please let us have proof of this so we can code your record accordingly.

PATIENT PARTICIPATION GROUP

The Practice is committed to improving the services we provide to our patients. To do this, it is vital that we hear from people about their experiences, views and ideas for making services better. Are you interested in getting involved **YES/NO**

CONSENT TO CONTACT

I consent to appointment confirmations / reminders / test results etc being sent to me

SMS TEXT MESSAGING **EMAILS**

☐ Consent Given ☐ Consent Refused ☐ Consent Given ☐ Consent Refused

☐ I confirm that I will update my details if they change.

PLEASE PROVIDE TWO SEPARATE FORMS OF IDENTIFICATION ONE FOR ADDRESS CONFIRMATION AND ONE PHOTO ID.

…… …… ……/……/……..

Your name (capitals) **Your signature** **Date**

For office use only Form accepted by …… (initials)

Named GP …… ☐ Informed patient of registered GP

Confirmation seen (this must be official and not confirmation of an online purchase for example)

☐ Driving licence, ☐ Utility bill, ☐ Bank statement, ☐ Other……..