New Patient Questionnaire (Age 16+)

Please complete the questionnaire as fully as possible.

Mr ☐ Mrs ☐ Miss ☐ Ms (Please tick)

Surname: _____

First names: _____

_____

Date of Birth: _____/_____/_____

Home Tel _____

Mobile* _____

Print Email address* _____

_____

Married ☐ Single ☐ Widowed ☐ Other ☐

* **We will use these details to send you healthcare information, but no clinical details**

Proof of ID provided: (Official use only)

Passport ☐ Driving licence ☐

Proof of Address provided:

Utility Bill ☐

Other ☐ _____

Next of kin

Relationship _____

Name _____

Address

_____

_____

Telephone _____

Ethnicity (Please tick)

White British ☐
White Irish ☐
White Other ☐

Black Caribbean ☐
Black African ☐
Black other ☐

Indian ☐
Pakistani ☐
Chinese ☐

Mixed -
White/Black Caribbean ☐
White/ Black African ☐
White/Asian ☐

Other (Please specify)

_____

First spoken language

Tick if you're a Carer? ☐
If yes, please ask for a Carer's Registration Form.

Tick if you have a carer? ☐
A carer is a person who is caring for someone who needs support because of age, frailty or long term medical, physical or learning disability; without being paid for the care they give.

Electronic Prescription Service	Please arrange for all my prescriptions to be sent to the pharmacy named below. I will notify the pharmacy and ask them to arrange for prescriptions to be collected by this method
Name and Address of Pharmacy	

Personal Medical History: please list any serious illnesses/Operations/accidents (and for women any pregnancy related problems) and the year they took place

Medical History of Diagnosis	Month of diagnosis	Year of diagnosis
E.G. Asthma	***June***	***2004***

Drugs and Medicines:
Are you allergic to any drugs or medicines? Yes ☐ No ☐

If yes, please state _____
Please attach your repeat order slip

Smoking Status

Never Smoked ☐

Ex-Smoker ☐
Date you gave up: _____

Current Smoker ☐
Amount per day _____

If you do smoke and would like help to stop please tick box ☐

Measurements

Height (CM):

_____

Weight (Kg)

_____

Waist Measurement:

_____(CM)

Alcohol Consumption

How often do you have a drink containing alcohol (Please tick one option)

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

How many drinks containing alcohol do you have on a typical day when you are drinking (Please tick one option)

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

How often do you have six or more drinks on one occasion? (Please tick one option)

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

WOMEN Only: Please be as accurate as possible

Have you had a smear test in the last 3 years	☐	Date_____Result _____
Was it carried out at your Doctors surgery?	☐	Where _____
Have you had a hysterectomy?	☐	When (Month/Year) _____
Do you take the contraceptive pill?	☐	Please specify _____
Do you have a coil/IUD fitted?	☐	When fitted/type _____
Are you pregnant?	☐	Estimated due date_____

We provide family planning and well woman screening. Smear tests are carried out by our nurses.
See our website www.centralsurgerysurbiton.co.uk for details

Family Medical History:
Has anyone in your immediate family suffered from any of the following (Tick where applicable):

Stroke (under the age of 60)	☐	Family member, if any:_____
Heart Disease (Angina, Heart attack)	☐	Family member, if any:_____
High blood pressure	☐	Family member, if any:_____
Diabetes	☐	Family member, if any:_____
Other: _____		Family member, if any:_____

Date _____

Do you need help with communication	Tick if yes
Large print	
Braille	
Induction loop	
British Sign Language	
Other (give details)	

Are you serving, or have you served, as a member of the British Armed Services	Yes/No
If yes, Service Number and date of discharge	

New Patient Check

Date/Time

New Patient Check

Date/Time

Or I do not wish to attend a New Patient Health Check

Signed Date

Central Surgery SURBITON

New Patient/Practice Agreement

Name (print)		Date of Birth		Initial to indicate your understanding and agreement
Below:	I = the Patient We = the Practice			
Disclosure				
I agree to disclose all material facts regarding my health to my General Practitioner and his/her clinical staff. We, the Practice, declare that we shall not disclose any information regarding you without your written consent, unless required to do so by a court order or any other legal obligation.				
Confidentiality				
We declare that we shall hold confidential all matters pertaining to you and not release such information, except in relation to managing your care (eg referral letter) without your written consent, unless required to do so by a court order or any other legal obligation.				
Evidence Based Medicine				
I understand and agree that Central Surgery clinicians practice evidence based medicine and as such they may make changes to my existing treatment in order to optimise my health care.				
Appointments				
I agree to **arrive on time for all appointments** that I book with the Practice, or to cancel in advance any appointment that I cannot attend. Cancelation can be made on line or by selecting **option 2** from the telephone menu. I acknowledge that if I arrive more than 10 minutes late for an appointment I will only be seen at the clinician's discretion, based on his/her assessment of my clinical need, and that I may be asked to wait until the end of the surgery, or to rebook for another time/day.				
Prescribing				
I understand and agree that Central Surgery do not believe in prescribing benzodiazepines (such as temazepam, nitrazepam, diazepam and Z drugs) unless for short term use. Central Surgery cannot guarantee that they will issue opiates or benzos- and especially not on the day I register. They have a policy on general withdrawal of these unless I am on a shared care scheme.				
Repeat Prescriptions				
I will give <u>two working days' notice</u> when requesting a repeat prescription. Furthermore I agree to make my request in writing: by email, fax or online. I acknowledge that requests cannot be made by telephone				
Test Results				
I understand that I can telephone for results of medical tests after 11 am. I acknowledge that **I am responsible for contacting the practice** for results, and that I will only be contacted by you in cases when I need urgent medical attention following a test.				
Home Visits				
I will only request a home visit from the Practice under circumstances where I cannot physically attend at the Practice, and have no one who can assist me. I will endeavour to make this request no later than 10:30 am.				

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Telephone appointments	
I understand that I may book a telephone consultation with a doctor or nurse, but I will not be able to speak with them whilst they are consulting with other patients.	
Out of Hours Services	
I agree to use the Out of Hours Services only where it is medically necessary, otherwise I will contact the surgery when it is next open.	
Out of Area Patients	
I acknowledge that I live outside the practice area and have registered since 15/01/2015. I am not therefore included in out of hours or home visiting services. [Delete if not relevant.]	
Non NHS Services	
I agree to pay fees for non NHS services (such as medical certificate for absences less than 7 days or private medicals etc). I understand such services are not covered under the NHS. I acknowledge that private letters and forms that are not clinically urgent may take up to 20 working days to process. I understand that all private fees must be paid in cash or by cheque when services are requested or when documents are collected.	
Zero Tolerance	
I agree with the policy of **Zero Tolerance** of abuse towards all NHS Staff and I agree **not** to behave in an abusive, threatening or otherwise aggressive manner with any member of the Practice Staff or others at the health centre. I acknowledge the right of the Practice to remove me from their List without appeal should I behave in a manner prohibited. I can expect to receive equal respect and curtesy from the Practice Staff.	
Bringing Children	
If you bring children to the surgery, we would be grateful if you would ensure they do not disturb other patients. Please supervise them at all times.	
Mobile Phones	
We welcome the use of mobile technology. Please make use of our Wi Fi, free for the first 10 minutes (longer for selected health care sites). We simply ask you to be sensitive to others when using your mobile phone; by muting the ringer (to vibrate only or silent) and speaking quietly and at a reasonable distance from others in the waiting room. We would request you not to use the phone facility whilst in a consultation.	
Food and Drink	
Please make use of the cooled water dispensers. Ask at Reception for a cup. Please supervise children using this facility and let us know if there is a spillage. If you have drinks or snacks while you are waiting for your appointment, please dispose of containers in the waste bins. Please do not eat hot food or drink alcohol in the waiting room.	

Signed		Date	