THE BANKS AND BEARWOOD MEDICAL PRACTICE

New Patient Questionnaire

Please compete in BLOCK CAPITALS and tick boxes as appropriate. Please make sure you have photo ID and proof of address when you are registering. If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment. If you require any assistance completing this form, please ask. This form is available in large print.

Full name: **Previous surname (if any):**	**Date of birth:**
Address:	**Previous Address:** Have you recently arrived in the UK? If so, when …
Telephone number: **Mobile number:** **Email address:**	**Marital Status:** **Occupation:**

ETHNICITY AND FIRST LANGUAGE DETAILS

The Practice, in line with other healthcare providers, collects information about the ethnic group of patients. All the information we receive will be used and treated with the strictest confidence. The level of care you will be offered will not be affected by your decision to complete this section. Please complete the form below by ticking the box, which indicates the ethnic group, which best describes you.

Please indicate your ethnic origin:

☐ British or mixed British ☐ Irish ☐ African ☐ Caribbean ☐ Indian ☐ Pakistani

☐ Bangladeshi ☐ Chinese ☐ Other (please state): ☐ Decline to state

Please indicate your first language:

☐ English ☐ Welsh ☐ French ☐ Spanish ☐ German ☐ Italian ☐ Polish
☐ Russian ☐ Dutch ☐ Swedish ☐ Greek ☐ Portuguese ☐ Hebrew ☐ Arabic
☐ Hindi ☐ Swahili ☐ Urdu ☐ Punjabi ☐ Cantonese ☐ Mandarin ☐ Japanese
☐ Thai ☐ Other Main Spoken Language: provide details
☐ Decline to state

ADDITIONAL NEEDS

Do you suffer from any form of disability? If so, please give details:

Do you have any specific communication needs (not including foreign language needs)?

☐ Yes ☐ No

If yes: Please ask Reception for the additional Communication Questionnaire.

PAST MEDICAL HISTORY: Please tick if you have had any of the following:

High blood pressure	☐	Diabetes	☐
Angina	☐	COPD / Asthma	☐
Heart attack	☐	Stroke / TIA	☐

Any other major illness or operation? If yes, please give dates & details:

Have you had a flu vaccination this year (eligible patients only)? ☐ Yes, Date given: ☐ No

FEMALES ONLY

Please give the date of your last smear or, if you have had a hysterectomy, the date of this.

IMMUNISATIONS

Have you had two doses of the measles, mumps and rubella (MMR) vaccine? (Rubella is also known as German Measles)
Dates of MMR immunisations:

Dates and details of any other past immunisations:

If you do not have written confirmation of past immunisation with two doses of the MMR, you may be susceptible to infection with rubella virus (German Measles). Rubella infection in pregnancy can cause severe abnormality and even the death of the baby. We offer rubella vaccination in the form of MMR vaccine to all who have not completed a course of this vaccine. (Please note this cannot be given in pregnancy as it is a live vaccine)

☐ I would like to book rubella immunisation

MEDICATION

Prescription requests must be made in writing. We do not accept them over the phone. We do offer an on-line service via our Practice website. Please ask for details on how to sign up to this service.

Do you take any regular medication (including the contraceptive pill)? ☐ Yes ☐ No
If YES, please list with dosage or attach repeat prescription slip from previous Doctor. Please note, the Practice abides by the Dorset CCG Drug formulary.

Are you allergic to any medication? (provide details)

ELECTRONIC PRESCRIBING SERVICES

If you would like to use the Electronic Prescribing Service which allows eligible prescriptions to be sent electronically, direct to a nominated pharmacy, please provide the name and address of the Pharmacy below.

LIFESTYLE

Your height: **Your weight:**

Your blood pressure:

(Please use the machine in the waiting room/outside reception)

SMOKING STATUS

Current smoker Yes ☐ No ☐ If yes, how many per day? ……

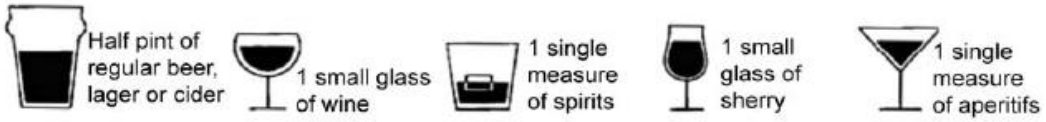
Have you ever smoked? Yes ☐ No ☐ If yes, when did you stop?

SMOKING SERIOUSLY DAMAGES YOUR HEALTH. FOR HEALTH AND ADVICE ON QUITTING, ASK RECEPTION FOR DETAILS ABOUT LIVE WELL DORSET OR CONTACT THEM ON 0800 8401 628

Alcohol Consumption

Please complete the following questions about alcohol by circling the appropriate box

One drink =



Question	Scoring System (circle answer)			
	0	**1**	**2**	**3**
How often do you have a drink that contains alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-8
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly

Scoring: A total of 5+ indicates hazardous or harmful drinking

Family History

Have any close relatives (father, mother, sister, brother only) ever suffered from any of the following?
(Please indicate who in the boxes)

Heart attack	Stroke	Diabetes	High blood pressure	Asthma	Glaucoma	Cancer

Carers

Are you a carer ☐ Yes ☐ No

Would you like our carers lead to contact you? ☐ Yes ☐ No

Do you have a carer ☐ Yes ☐ No If yes, name and address:

DATA SHARING CONSENT CHOICES

To maintain continuity of clinical care, we upload **certain** medical information so that it is available to other healthcare organisations (e.g. Emergency Departments). Please read and keep the accompanying Data Sharing leaflet which details which part/s of your record are extracted and how it is used to help other NHS organisations. Please complete the Consent / Opt Out form attached to the Data Sharing Leaflet.

Where you have provided information on how to contact you, can you confirm you are happy for The Banks and Bearwood Medical Practice to contact you by the following:

By email ☐ Yes ☐ No This will be to send you letters, newsletters and the like
By text ☐ Yes ☐ No This will be to send you reminders of appointments via text

I confirm that the information I have provided is true to the best of my knowledge.

Signed: _____ Date: _____

Signature of patient ☐ Signature on behalf of patient ☐ (indicate relationship) _____

Thank you for your co-operation, The Banks and Bearwood Medical Practice

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For administrative use only

Forms checked by: Proof of ID and address:

Date:

BP reading: Referred Nurse ☐ Referred GP ☐ Appt date:

Refer for a Nurse appointment if best reading is higher than 150/90
Refer for a GP appointment if best reading is higher than 180/110