New Patient Health Questionnaire

We respect your right to privacy and assure you that we will keep all your health and personal information confidential and secure within the practice.

Please complete as many questions as you can. The information will help the practice to provide better medical care or you. The information will be held in the strictest confidence as per Data Protection.

Your Contact Details*

Title
Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Surname

Date of Birth

First Names

Occupation

Previous Surnames

Home Address

Previous Address

Postcode:

Home Tel
Mobile
Work Tel
Email
(Please provide an email address where possible)

Are you new to this country?

Date you came into the UK?

Information About You*

What is your height?
What is your weight?
What is your blood pressure?

You can use the height/weight and BP monitor in reception to record these.

What is your first language?

Do you require a translator?

Ethnic Group*

White British ☐ Irish ☐ Other ☐ Please State:

Black Caribbean ☐ African ☐ Other ☐ Please State:

Asian Indian ☐ Pakistani ☐ Chinese ☐
Other ☐ Please State:

Mixed White + Black ☐ Caribbean White + Black African ☐
White + Asian ☐ Other ☐ Please State:

Previous GP*

Name and Address of Previous GP

Medical Information*

Please list any serious illnesses / operations / accidents / disabilities and for women any pregnancy related problems) and the year they took place:

Have you ever suffered from? (tick as appropriate)*

Epilepsy	Yes / No	Blindness/Glaucoma	Yes / No
High Blood Pressure	Yes / No	Diabetes	Yes / No
Heart Attack/Stroke	Yes / No	Depression	Yes / No
Cancer	Yes / No	Asthma	Yes / No
Eczema/Hay Fever	Yes / No	COPD	Yes / No

Please list any medicines being taken and the amount:*

Are you a Military Veteran? (Code:13Ji) **Yes/No**

Are you registered disabled?* (If yes, please give details) Yes / No

Are you allergic to any medicines and if so, which?*

Yes / No

Have you ever refused treatment/screening of any kind and if so, what?*

Yes / No

Have you ever suffered from?* (tick as appropriate)

Anxiety Yes / No Depression Yes / No
OCD Yes / No Bipolar Disorder Yes / No

Do you have any other mental health issues?* (If yes please give details)

Are you receiving or have you received any treatment or therapy?* (If yes please give details)

Carers*

Do you have a carer? (If yes please give details) Yes / No

Are you a carer? (If yes please give details) Yes / No

NHS Health check offered Yes/No

Women*
Have you ever had a cervical smear? Yes / No
(Please state the last date)

Smoking*

Do you smoke? Yes / No

If 'No', have you ever smoked? Yes / No

If you do currently smoke, how many cigarettes or ounces of tobacco do you smoke per week?

Would you like advice on giving up smoking? Yes / No

Alcohol*

1 drink = 1/2 pint of beer or 1 glass of wine or 1 single spirits

MEN: How often do you have EIGHT or more drinks on one occasion?

WOMEN: How often do you have SIX or more drinks on one occasion?

Never ☐ Less than Monthly ☐ Monthly ☐ Weekly ☐ 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 ☐

How often during the last year have you failed to do what was normally expected of you because of drinking?

Never ☐ Less than Monthly ☐ Monthly ☐ Weekly ☐ Daily ☐

In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

No ☐ Yes, on one occasion ☐ Yes, more than once ☐

Family History*

Please state any serious illness, in particular cancer, heart disease, stroke, high blood pressure, diabetes or any inherited disease. Please state your relationship to the individual and in the case of cancer, the type of cancer.)

Accessible Information Standards

For patients who have a disability, impairment or sensory loss who require communication support.

Do you require correspondence in: (Please tick)

Large print
Audio Tape
Braille

Your preferred communication method: (Please tick)

Telephone
Letter
Email

Next of Kin*

Please give name, address and telephone number of next of kin

For patients aged 65 and over or those with a chronic disease* (e.g. asthma or diabetes)

Have you had a flu vaccination? Enter date or 'never':

Have you had a pneumococcal vaccination? Enter date or 'never'

Parental Responsibility

Information if registering someone under 16

Please state who has Parental Responsibility

Name_____ Relationship to child_____

Name_____ Relationship to child_____

If you are not sure please see below

- Mothers and married biological fathers automatically have Parental Responsibility and will not lose it if divorced.
- Unmarried biological fathers do not automatically have Parental Responsibility unless they have registered their name on the birth certificate.
- Step-fathers and Step-mothers do not automatically have Parental Responsibility.
- Grandparents do not automatically have Parental Responsibility
- Foster carers do not hold Parental Responsibility (but will hold a degree of delegated authority to make routine decisions around a child's health)
- The Local Authority will share Parental Responsibility with the parents if on a Care Order.
- A child can be accommodated by a Local Authority but not be subject to a care order or placement order. Where a child is voluntarily accommodated by a Local Authority under a section 20, Parental Responsibility remains with the parent; the Local Authority does not share Parental Responsibility but the child is still 'Looked after'.
- A Special Guardianship Order grants Parental Responsibility to the child's 'special guardian'

Gender Identity/Trans Status

Which of the following options best describes how you think of yourself?

Woman (including trans woman) ☐

Man (including trans man) ☐

Non-binary ☐

In another way (please state) ☐

Is your gender identity the same as the gender you were given at birth? Yes ☐ No ☐

Sexual Orientation Monitoring

Which of the following options best describes how you think of yourself?

Heterosexual or straight ☐

Gay or Lesbian ☐

Bisexual ☐

In another way (please state): _____

Patient On-Line Services

From August 2016 you can request access to your full coded medical record or just use it to order medication and make appointments.

If you want to use Patient Online Access please complete a registration form and once your identity is confirmed, we can provide you with log on details for you to register on-line.

Patients who are 16 and over can register for Patient Online Access.

Please ask for a leaflet from reception for further information.

Signature:

Date:

Albion Medical Practice
Patient Consent for Email and Text Message Communication

The practice wishes to expand its methods of communicating with patients to include the use of email and text messaging.

Patient Privacy is important to us, and Albion Medical Practice would like to communicate with you regarding any activities that may be of interest, which means that we need your consent.

This may include using emails to provide updates on new developments at the practice, and the use of text messaging to send patients reminders about the details of their next appointment and health campaigns.

Emails and text messages are generated using a secure facility, but because they are transmitted over a public network they may not be secure. Email and text communication will never be used for urgent communications. Your contact details will be used solely in relation to healthcare services offered by the practice, and you can choose to opt out of the services at any time by contacting reception.

Please complete this form and hand it in at the practice reception
If you consent to any, or all, of the above.

Patient Name _____ **Date of Birth** ...../...../.....

Mobile _____ **Consent to use?** Y N

Email _____ **Consent to use?** Y N

_____

_____

Signature _____ **Date** _____

Please confirm your consent to one (or more) of the following;

- ☐ **Newsletters (and similar communications)**
- ☐ **MJOG text reminders for appointments**
- ☐ **MJOG texts for health campaigns (Flu, Pneumococcal, Shingles ect)**