TODAYS DATE:-……

DANETRE MEDICAL PRACTICE - NEW PATIENT QUESTIONNAIRE

NAME:-……

ADDRESS:- ……

……

POST CODE: ……

TEL: HOME……MOBILE……

EMAIL……

DATE OF BIRTH……

PLACE OF BIRTH……..

MARITAL STATUS……....

NEXT OF KIN

Name……

Contact number……

Relationship to you……..

ETHNIC GROUP - PLEASE CIRCLE

WHITE	**BLACK or BLACK BRITISH**
A - White British	M - Black Caribbean
B - White Irish	N - Black African
C - Other white	O - Other Black

MIXED
D - Mixed - White and Black Caribbean
E - White and Black African
F - White and Asian
G - Other mixed

ASIAN OR ASIAN BRITISH	**OTHER ETHNIC**
H - Indian	R - Chinese
J – Pakistani	S - Other ethnic
K - Bangladeshi	category
L - Other Asian	Z - Not stated

IF YOU ARE ON ANY REPEAT MEDICATION PLEASE GIVE YOUR REPEAT REQUEST SLIP TO RECEPTION

(1) DO YOU SUFFER, OR HAVE YOU EVER SUFFERED, FROM ANY OF THE FOLLOWING: (Circle which applies)

Heart Disease YES/NO Stroke YES/NO Heart Attack YES/NO

High Blood Pressure YES/NO Asthma YES/NO

Diabetes YES/NO
If yes is this (please circle), Type 1 Type 2 Gestational Steroid Induced Pre-diabetes Don't know

(2) Does ANY Member of your FAMILY suffer from any of the ABOVE PROBLEMS?
IF YES, please state PROBLEM and RELATIONSHIP to YOU.

1 …… 2 …… 3 ……

(3) Have you ever been diagnosed with Cancer? YES/NO
IF YES, please state what type of cancer……

(4) Have you ever had a major operation? YES/NO
IF YES, please state what type of operation……

(5) ARE YOU ALLERGIC TO ANYTHING: Medication, Animals, Food, Plants? YES/NO.

IF YES, PLEASE LIST BELOW

1 …… 2 …… 3 ……

(6) Do you have any communication / information needs relating to a disability, impairment or sensory loss? If so, please state

……

PTO

(7) DO YOU SMOKE? IF YES - HOW MANY A DAY? …… If NO – HAVE YOU EVER SMOKED YES/NO

SMOKING IS DANGEROUS TO YOUR HEALTH

WOULD YOU LIKE TO RECEIVE HELP AND ADVICE ON HOW TO STOP SMOKING? YES/NO

(8) DO YOU DRINK ALCOHOL? YES/NO IF YES - HOW MANY UNITS A WEEK? ……..

(9) ARE YOU A CARER? YES/NO IF YES – Please complete a carers' register leaflet

(**10) DOES SOMEONE CARE FOR YOU?** YES/NO IF YES – Please get them to complete a carer's register leaflet

(11) DO YOU WANT SOMEONE ELSE TO HAVE ACCESS TO YOUR MEDICAL RECORDS? YES/NO
IF YES – Please ask for an access to medical records form

(12) WHAT IS YOUR WEIGHT? …… **WHAT IS YOUR HEIGHT? ……..**

(13) BEFORE ANSWERING THE FOLLOWING QUESTION PLEASE READ THE LETTER YOU HAVE BEEN GIVEN ABOUT THE NHS SUMMARY CARE RECORD

YES – I would like a summary care record to include:-

a) ☐ **Core information only** – medication, allergies and adverse reactions

OR

b) ☐ **Core information plus additional information** - which may include active medical problems, vaccinations, anticipatory care information, end of life care information

A summary care record will automatically be created for you. You may change your mind and opt out at any time.

NO – ☐ I do not want a summary care record – Please ensure you ask a member of staff for an opt out form and complete this and hand it to a member of staff You may change your mind at any time.

If you would like more information please read the NHS Summary Care Record Leaflet

(14) HAVE YOU EVER SERVED IN ANY OF THE ARMED FORCES?

☐ **Yes** – please state which ……
☐ **No**
If yes please give enlistment dates……

(15) DO YOU HAVE A LIVING WILL?

☐ **Yes** – please supply us with a copy for your records
☐ **No**

BLOOD PRESSURE

Please take your Blood Pressure using the automatic blood pressure monitor in the waiting area. It is very easy to use and prints off a ticket with the current reading. Please ask for the ticket to be attached to your questionnaire when you hand it in. If your Blood Pressure is over 150/90 please make an appointment to see the Practice Nurse.

PATIENT NEEDS

All staff within the Practice will endeavour to ascertain whether patients have specific needs they require meeting in order for them to be fully involved in their care. Please tell us here if you have any specific needs, other than the communication/information needs you have identified on the previous page:

……

……

Getting involved in the Practice	We support clinical research
We are committed to ensuring our patients are fully involved in the development of services as we believe that our patients have an important contribution to make in our future development. If you are interested in knowing more please tick the box: ☐	Taking part in a clinical research study is **voluntary,** and can be a rewarding experience. Help us to: • Find out which treatment works best • Investigate new ideas • Have a greater understanding of diseases • Improve diagnosis and treatments If you are interested in learning more or being on our research database should a relevant trial become available to your condition please tick ☐ box

I would like to receive communications from Danetre Medical Practice in relation to any new services that may be of interest to me.

LETTER ☐ EMAIL ☐ TEXT ☐ TELEPHONE ☐

I understand that I can opt out at any time by informing the practice.

☐ I confirm that I have been given a copy of the practice Privacy notice.

Signature

……

For Office Use Only

☐ Photo ID seen & copied ☐ Proof of address seen ☐ Email sent to HVs (if applicable)

☐ Named GP form given (over 75's only)

☐ Named GP code added (Xab9D) ☐ Consent code added (Y1c49)

☐ Opt-out form received ☐ Opt-out form NOT received ☐ Opt-out code added to patient record (XaXj6)

Staff signature ……..