Updated: May 2020

Beaconsfield Surgery New Patient Health Questionnaire

Date: ..... **Title: Mr [ ]Mrs [ ] Miss [ ] Ms [ ] Mx [ ] Other [ ]**

Forename..... **Pronouns: eg: She/Her, They/Their**.....

Surname ..... **Sex: Male [ ] Female [ ] Non-binary [ ] None Specified [ ]**

Address ..... **Sex Assigned at Birth: Male [ ] Female [ ] Intersex [ ]**
I would prefer not to say [ ]
..... (We ask for your assigned sex to help us screen for Sex-specific diseases such as cervical/prostate cancer)

.....

Ethnicity.....
Post Code ..... (As some ethnic communities are susceptible to certain Disease)

Date of Birth.....

Which of the following best describes your religion
Marital Status..... **(NB. These questions are to comply with the discrimination act of 2010)**
None [ ] Buddhist [ ] Christian [ ] (incl. Church of England,
Occupation..... **Catholic, Protestant** and other **Christian denominations)**
Hindu [ ] Muslim [ ] I would prefer not to say [ ]

 **Tel No: Home** .....  **Work** .....  **Mobile**.....

Are you happy for us to leave messages on your telephone? Yes [ ] No [ ]

I consent to the practice contacting me by text/sms messaging on the mobile number above Yes [ ] No [ ]

I consent to the practice contacting me by e-mail on the following e-mail address :_____
and for it to used for any clinic or hospital appointments that I am referred to Yes [ ] No [ ]

Previous Doctor .....

Are you disabled Yes [ ] No [ ]

First Language Spoken.....

Do you require an interpreter [ ]

Do you have any additional communication needs? Please state.....

Do you consent to us sharing your communication needs with other health care professionals? Yes [ ] No [ ]

Are you the main carer for anyone in your household (please state) Yes [ ] No [ ]

Next of Kin: Name.....

Address: .....

..... **Tel:** .....

Is your Next of Kin registered at this surgery Yes [ ] No [ ]

Your relationship to next of kin.....

Please confirm if you are happy for the GP to discuss medical issues with your named next of kin Yes [ ] No [ ]

Updated: May 2020

Beaconsfield Surgery New Patient Health Questionnaire

Medication

Do you take any medications? Include the name, dose and frequency that you take them – or attach your repeat prescription request sheet. Please state which medicine you purchase from the chemist.

The practice supports EPS (Electronic Prescribing Service – which enables prescribers to send prescriptions electronically to a nominated pharmacy of the patient's choice via the NHS spine). Would you like to nominate a pharmacy or have you previously nominated a pharmacy for your prescriptions to be sent to automatically?

Nominated Pharmacy:…….

Do you have any allergies (please state) Yes [ ] No [ ]

PAST MEDICAL HISTORY:
Please list any illness you have

HOSPITAL ADMISSIONS:
Please list and include dates of any operations if possible

Have you got a long term condition Yes [ ] No [ ]
(please state)

DO YOU SUFFER FROM ANY OF THE FOLLOWING:

High blood pressures	**Yes [ ] No [ ]**	**Diabetes**	**Yes [ ] No [ ]**
Heart disease	**Yes [ ] No [ ]**	**Epilepsy**	**Yes [ ] No [ ]**
Asthma	**Yes [ ] No [ ]**	**Migraine**	**Yes [ ] No [ ]**
Mental illness of any type	**Yes [ ] No [ ]**	**Kidney problems**	**Yes [ ] No [ ]**
Hearing problems	**Yes [ ] No [ ]**	**Bowel problems**	**Yes [ ] No [ ]**
Sight problems	**Yes [ ] No [ ]**	**Urinary problems**	**Yes [ ] No [ ]**
Arthritis	**Yes [ ] No [ ]**	**Indigestion**	**Yes [ ] No [ ]**
Blood problems	**Yes [ ] No [ ]**	**Cancer**	**Yes [ ] No [ ]**
Thyroid problems	**Yes [ ] No [ ]**	**Stroke/TIA**	**Yes [ ] No [ ]**

Please provide details you feel are relevant to the above

Please indicate if you have a family history of stroke or heart disease:
Mother or sister (before age 65) Yes [ ] No [ ]
Father or brother (before age 55) Yes [ ] No [ ]
<u>If Yes please give further details.</u>

HEIGHT:……metres/feet

WEIGHT:…… kg/ stones

SMOKING:

Have you <u>ever</u> smoked cigarettes or tobacco? Yes [ ] No [ ]

Are you a smoker now? Yes[ ] No [ ] how many?

If you are an ex smoker when did you give up?

Updated: May 2020

Beaconsfield Surgery New Patient Health Questionnaire

Would you like advice on how to give up? Yes [ ] No [ ]

DRINKING

How often do you have a drink containing alcohol?

Never [ ] Monthly or less [ ] 2 to 4 times a Month [ ] 2 to 3 times a Week [ ] 4 or more times a week [ ]

How many units of alcohol do you drink on a typical day when you are drinking?

1 or 2 drinks [ ] 3 or 4 drinks [ ] 5 or 6 drinks [ ] 7,8 or 9 drinks [ ] 10 or more drinks [ ]

How often have you had Six or more units (if you are female) or Eight or more units (if you are male) on a single occasion in the last year?

Never [ ] Less than Monthly [ ] Monthly [ ] Weekly [ ] Daily or almost daily [ ]

EXERCISE

Do you take 30 minutes a day of at least moderate exercise more than 5 times per week?

Do you take less than 30 minutes a day of physical exercise 5 times a week?

What type of exercise?

DIET

Do you have a special diet? (please state)

Intake of fruit and vegetables less than 5 portions daily?

Intake of fruit and vegetables at least 5 portions daily?

IMMUNISATIONS:

Please tick box if yes and provide if possible

Updated: May 2020

Beaconsfield Surgery New Patient Health Questionnaire

Tetanus	**[ ]……..**	**Flu**	**[ ]…….**	**Typhoid**	**[ ]…….**
Polio	**[ ]……..**	**Hepatitis A**	**[ ]…….**	**Yellow Fever**	**[ ] …….**
MMR	**[ ] …….**	**Hepatitis B**	**[ ] …….**	**Pertussis**	**[ ] …….**
Rubella	**[ ] …….**	**BCG**	**[ ] …….**	**(whooping cough)**	
Diphtheria	**[ ] …….**	**Meningitis**	**[ ] …….**		

Please give the name, relationship and date of birth of any family members who live with you and are registered at this practice;

THIS SECTION TO BE FILLED IN FOR/BY UNDER 16's ONLY

Name of Parent/Guardian ……..

School ……..……

Do you provide regular care to anyone in your household, a family member, friend or neighbour? (please state) Yes [ ] No [ ]

Safeguarding Our Patients

Beaconsfield Medical Practice is committed to safeguard and promote the welfare of children, young people and vulnerable adults who attend our surgery, if a member of staff is concerned regarding a patient's welfare they have a duty of care to act on that concern.

INFORMATION MAY BE SHARED WITH OTHER PROFESSIONALS

Are you/a member of your family currently subject to or have previously been subject to a child protection plan or 'Looked after Child' care plan? Yes [ ] No [ ]

If yes, who does this relate to?

NHS HEALTH CHECK

If you are aged between 40-74 and not already under review for a chronic disease? Then you are eligible for a free NHS Health Check. Would you like to book a health check? YES [ ] NO [ ]

If you are not entitled to the NHS Health Check above you can have a New Patient Health Check. This 20 minute appointment includes blood pressure, BMI, lifestyle counselling, routine urine testing and cholesterol check if felt necessary. We also offer Chlamydia screening for under 25s. Please contact reception to make an appointment.

Updated: May 2020

Beaconsfield Surgery New Patient Health Questionnaire

The practice has a patient participation group who meet every three to four months. Would you be interested in becoming a member?

YES [ ] NO [ ]

Armed Forces

Are you currently serving in the UK Armed Forces Yes [ ] No [ ]

Have you ever served in the UK Armed Forces Yes [ ] No [ ]

Updated: May 2020

Beaconsfield Surgery New Patient Health Questionnaire

Your Summary Care Record (SCR) and your Summary Care Record with Additional Information (SCRAI)

If you are registered with a GP practice in England, you will already have a **Summary Care Record (SCR)** unless you have previously chosen not to have one.

It **only** contains information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

A **Summary Care Record with Additional Information (SCRAI)** contains significantly more useful information. It can include information about medication, allergies, adverse reactions, your illnesses and health problems, operations, vaccinations, how you would like to be treated (such as where you would prefer to receive care) what support you might need and who should be contacted for more information about you.

Having a **SCR** or **SCRAI** helps by providing the NHS healthcare staff that are treating you with vital information from your health record. This will help the staff (especially if they do not know you) make better and safer decisions about how best to treat you.

You have the choice of what information you would lie to share and with whom. Please note only authorised NHS healthcare staff can only view your **SCR** or **SCRAI** with your permission and using an auditable means of access. The information shared will solely be used for the benefit of your care and remains confidential.

You can select the option of your choice on the following page.

Updated: May 2020

Beaconsfield Surgery New Patient Health Questionnaire

You have a choice- Having read the above information regarding your choices, please choose one of the options below:

Yes – I would like a Summary Care Record

□ **SCRAI**- Express consent for medication, allergies, adverse reactions and additional information.

□ **SCR –** Express consent for medication, allergies and adverse reactions only.

Or

No – I would not like a Summary Care Record

□ Express dissent for Summary Care Record

Name of patient……

Date of birth……..

Signature…….. Date……

If you are filling out this form on behalf of another person, please ensure that you fill out their details above; you sign the form above and provide your details below:

Name:……

Please circle one: Patient Legal Guardian Lasting Power of Attorney and Welfare