The Jolly Medical Centre

New Patient Questionnaire

Welcome to The Jolly Medical Centre.

To register with this practice please complete this questionnaire as fully as possible. The questions have been designed to help your new GP get to know you and your medical history. It may take some time for your previous medical records to reach us. The information you give will help us provide you with good medical care.

Personal Details

Title		Have you been registered here before?	Yes ☐ No ☐
Surname		Previous name	
Forename(s)		Address	
Date of birth			
NHS number			
Home Tel. No.		Postcode	
Mobile Tel. No.		Email	
Work Tel. No.		Occupation	
Next of kin		Relationship	
Contact No		Address	

Sexual Orientation		Gender	
	Heterosexual ☐		Male (including Trans) ☐
	Bisexual ☐		Female (including Trans) ☐
	Homosexual (Gay or Lesbian) ☐		Other (please specify)
	Other (please specify)	Is your gender the same as you were assigned at birth? **Yes** ☐ **No** ☐	
Status	Single ☐ Married ☐ Civil Partnership ☐ Cohabitating ☐ Separated ☐ Divorced ☐ Widowed ☐		

Consent given to contact for notification via→ 1) Email ☐ 2) Mobile

Health Details

Alcohol – alcohol use can affect your health and can interfere with certain medications and treatments.
You answers will remain confidential so please be honest.
Use the guide below to decide how many units you drink a week.

Do you drink any alcohol?	Yes ☐ No ☐
How many **units** week?	
Drugs	
Do you have a drug addiction?	Yes ☐ No ☐

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Are you a smoker?	Yes ☐ No ☐	How many a day?		
Would you like support and/or information on giving up?				Yes ☐ No ☐
Stopped smoking?	Yes ☐ No ☐	When?		
Never smoked?	Yes ☐ No ☐			

Medical History Do you have, or have had, any serious health problems (including operations/ long term conditions?			
		Details	Date (if known)
Asthma	☐		
Cancer	☐		
COPD	☐		
Chronic kidney disease	☐		
Diabetes	☐		
Epilepsy	☐		
Heart attack/disease	☐		
High blood pressure	☐		
High cholesterol	☐		
Osteoporosis	☐		
Stroke	☐		
Mental health problems	☐		
Underactive thyroid	☐		
Circulation problems	☐		
Other serious illnesses	☐		
Any operations	☐		
Any known allergies	Yes ☐ No ☐	Allergic to	
Details of reaction			

Repeat Medication	
Are you on any repeat medication?	Yes ☐ No ☐
If 'yes', do you have a repeat prescription slip from your previous GP?	Yes ☐ No ☐

If 'Yes', please hand in at Reception. If 'No' then list below any current medication you are taking and make sure you show Reception all your medication in its original packaging and labelling. We may need to contact your previous GP surgery to confirm your medication.

Name of drug	Frequency (how often drug is taken)	Reason for using drug

Family Medical History

Have any of your immediate relatives (brothers/sisters/parents) had any of the following?

		Details	Relationship	Date (if known)
Heart attack or angina before 60				
Heart attack or angina over 60				
Asthma				
Diabetes				
Stroke				
Cancer				
Any inherited diseases				

Hospital Care (the doctor may discuss with you the possibility of transferring you care to a local hospital)

Are you currently under hospital care?	Yes ☐ No ☐	If 'yes' please complete details below
Hospital Name	Name of Consultant	Nature of problem

Do you consider yourself to have a disability?			Yes ☐ No ☐	
Details of impairment	Physical impairment		Learning disability/difficulty	
	Sensory impairment		Mental health condition	
	Other (please state)			
Are you a carer?	Yes ☐ No ☐	Is someone a carer for you?	Yes ☐ No ☐	

Ethnicity – How would you describe your ethnicity?

White	British	Irish	Other white		
Asian	Asian British	Bangladeshi	Indian	Pakistani	Other Asian
Black	Black British	African	Caribbean	Other black	
Mixed	Asian & White	Asian & Black	Asian & Caribbean	White African	White Caribbean
Other	Chinese	Japanese	Middle Eastern	Turkish	Any other Ethnicity

Please advise us on your first Language	English	Other (please state)	

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Screening and Contraception

Date of last cervical smear			Are you pregnant? Yes ☐ No ☐		
Have you had a hysterectomy?	Yes ☐ No ☐				
Contraception – what is your current method of family planning?					
None		Coil		Injection	
Contraceptive Pill		Sterilisation		Implant	
Condom		Partner had vasectomy		Hysterectomy	

Children Only

Please provide details of all vaccinations		Date			Date
Diphtheria/Tetanus/ Whooping cough/ Polio	1		Meningitis C	1	
	2			2	
	3			3	
Pneumococcal	1		Hib	1	
	2			2	
	3			3	
Measles/ Mumps/ Rubella (MMR)	1		Hib booster		
	2		Men C booster		
Preschool Diphtheria/Tetanus/Whooping cough/Polio			HPV	1	
Rubella				2	
BCG				3	
Teenage booster Diphtheria/Tetanus/Polio			Other:		
Other:			Other:		

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Application for online access to my medical record

Surname	Date of birth
First name	
Address Postcode	
Email address	
Telephone number	Mobile number

I wish to have access to the following online services (please tick all that apply):

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. Accessing my medical record	☐

I wish to access my medical record online and understand and agree with each statement (tick)

1. I have read and understood the information leaflet provided by the practice	☐
2. I will be responsible for the security of the information that I see or download	☐
3. If I choose to share my information with anyone else, this is at my own risk	☐
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	☐

Signature	Date

For practice use only

Patient NHS number		Practice computer ID number
Identity verified by (initials)	Date	Method Vouching ☐ Vouching with information in record ☐ Photo ID and proof of residence ☐
Authorised by		Date
Date account created		
Date passphrase sent		
Level of record access enabled All ☐ Prospective ☐ Retrospective ☐ Detailed ☐ Limited parts ☐ Contractual minimum ☐		Notes / explanation