WALM LANE SURGERY: New Patient Questionnaire

- As part of our registration process please complete this questionnaire as fully and accurately as possible.
- If you have difficulty completing this form please ask at reception for help

Personal Details

First Name		Surname	
Address		Email Address	

Telephone:	Home: Land Line		Mobile Number	

Date of Birth		Occupation: (if applicable)		Retired	

Ethnicity Monitoring – Please tick one:

White	A	☐	British	**Asian**	H	☐	Indian
	B	☐	Irish		J	☐	Pakistani
	C	☐	Any other White background		K	☐	Bangladeshi
Mixed	D	☐	White & Black Caribbean		L	☐	Any other Asian background
	E	☐	White and Black African	**Black**	M	☐	Caribbean
	F	☐	White and Asian		N	☐	African
	G	☐	Any other mixed background		P	☐	Any other Black background
				Other	R	☐	Chinese
	S	☐	Any Other Ethnic Group		Z	☐	Not stated

Language Support

What is your main spoken language?					Do you require an interpreter for appointments at the practice?	Y	☐	N	☐
Are you a Refugee?	Y	☐	N	☐	Are you an Asylum Seeker?	Y	☐	N	☐

Medical Conditions

Do you suffer from any of these conditions? Please tick, if relevant

Condition		*Date of onset*	**Condition**		*Date of onset*	**Condition**		*Date of onset*
Asthma	☐		Heart Attack/s	☐		Hypertension	☐	
Diabetes	☐		COPD	☐		Other:	☐	
Heart Failure	☐		Depression	☐			☐	

Previous Operations

Have you had any operations?	Yes	☐	If Yes, Please list below	No	☐

Type of operation		**Date**	**Type of operation**		**Date**
1			**2**		

Medication				
Do you take regular medication	*Y*	☐	*N*	☐

If you take regular medication please attach a list of your medication with this form
Thank you

Allergies

Are your allergic to anything that you know of?

None	☐	
Food	☐	*Name:*
Drug / Medicine	☐	*Name:*
Other Allergy	☐	*Name:*

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Lifestyle

Do you smoke?	Never	☐	Ex-Smoker	☐	Yes	☐	**If you are an ex-smoker?**	When did you stop? Year:	
								How many per day?	

Please confirm what and how much you smoke on a daily basis – tick below

Cigarettes	☐		*Per day*	Cigars	☐		*Per day*	Pipe	☐		*Per day*
Roll your own	☐		*Per day*	Vaping	☐		*Per day*				

If you are a smoker we will send you a Smoking Cessation leaflet for advise on giving up

How would you describe your diet?	*Good*	☐	*Average*	☐	*Poor*	☐

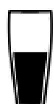
Exercise – *Please tick one*

Inactive	☐	Moderately inactive	☐	Moderately active	☐	Active	☐
Sedentary job and no physical exercise		*Sedentary job + less than 1 hour exercise per week or standing job and no physical exercise*		*Sedentary Job + 1 to 3 hours exercise per week or standing job and less than 1-hour physical exercise or physical job and no physical exercise*		*Sedentary job + 3 hours exercise or standing job +1 to 3 hours exercise or physical job and less than 1-hour exercise heavy manual job*	

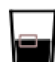
Height		cms		feet / ins	**Weight**		kg		st lbs

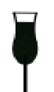
How many units of alcohol do you drink a week?	*Spirits*		*Wine*		*Beer*	

One unit of alcohol


Half pint of "regular" beer, lager or cider

Half a small glass of wine


1 single measure of spirits


1 small glass of sherry

1 single measure of aperitifs

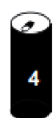
Drinks more than a single unit

Pint of "regular" beer, lager or cider

Pint of "strong" or "premium" beer, lager or cider

Alcopop or a 275ml bottle of regular lager

440ml can of "regular" lager or cider



440ml can of "super strength" lager

250ml glass of wine (12%)

75cl Bottle of wine (12%)

Alcohol Screening 1

Alcohol use disorders identification test; primary care (AUDIT PC)	Please complete the following questions?

Questions	**Scoring system**					**Your score**
	0	**1**	**2**	**3**	**4**	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 times or more per week	
How many units of alcohol do you drink on a typical day when you are drinking?	0 to 2	3 to 4	5 to 6	7 to 8	10 or more	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Audit Score:

If you scored 5 or more on the Audit-C above, is a positive screen **indicating increasing or higher risk drinking.**

it would be helpful for you to complete this more detailed **Audit-10 questionnaire** to see if you are drinking safely or need to cut down

Alcohol Screening 2

Alcohol use disorders identification test; primary care (AUDIT PC)

Please complete the following questions?

Questions	Scoring system 0	1	2	3	4	Your score
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost 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 or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	

Scoring:

0 – 7 indicates low risk

8 – 15 indicates increasing risk

16 –19 indicates higher risk

20 or more indicates possible dependence

If you feel you have a problem with alcohol, please make an appointment to discuss with a doctor

Audit Score

Family History

Have any of your blood relatives suffered from the following conditions:

	Condition	*Relationship to you*		*Condition*	*Relationship to you*
☐	Heart Disease		☐	Diabetes	
☐	Heart Attack/s		☐	Cancer: *Please specify*	
☐	High Blood Pressure		☐	Other Serious Illness *Please specify:*	
☐	Stroke		☐		

Carer & Next of Kin Information

Definition of a carer	*A carer is anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support*

Are you a carer?	*Y*	☐	*N*	☐	If Yes – Who do you care for?	
Are you looked after by a carer?	*Y*	☐	*N*	☐	If Yes – Who cares for you?	

If you are a carer would you like to be referred for carer support in this area? (Brent Carers) Click here for information on Brent Carers	*Yes*	☐	*No*	☐

Name, relationship & telephone number of your next of kin

Full Name		*Relationship*		*Contact number*	

For Female Patients Only

When did you last have a cervical smear?	*Date*	*Result*	*When is you next smear due?*	*Date*
Have you had a hysterectomy?	*Y* ☐ *N* ☐			

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Communications and Information needs (Please tick if relevant)					
Accessible Information Standard: Do you have any communication / information needs relating to a disability or sensory loss and if so what are they?					
Blind or have some visual loss	☐	Learning disability	☐	Other	☐
Deaf or Deaf or have some hearing loss	☐	Aphasia	☐	*Please specify*	
Deafblind	☐	Autism	☐		

Information needs – Format required (Please tick if relevant)							
Large Print	☐	Easy to Read	☐	Via Email	☐	Braille	☐
Other Support		*Please inform us:*					

SMS (text messaging) Consent

We use one and two way (some allow replies) text messaging extensively, from basic appointment reminders to health advice (including useful documents and links), test results, health campaigns (such as the flu vaccinations) and other useful information.

We also use it to set up video consultations. We will not bombard you and will only use it for relevant matters concerning your health. You can opt out at any time.

Please indicate your choice for SMS: Tick one only	*I **DO** wish to receive SMS (I understand that I can opt out at any time*	☐	*I **DO NOT** wish to receive SMS*	☐

Services you can sign up for today: Consent required

Patient Access	*EMIS Patient Access, offers internet access and an App to our appointment system, repeat prescription ordering, viewing medical records and test results and lots of information about local services and medical advice, videos and self-help material. Click here for further information*

Your Patient Access Consent

*I **DO** wish to sign up for Patient online Access*	☐	*I **DO NOT** wish to sign up for Patient online Access*	☐

*We will send you an **activation code / PIN letter** to your email address*

Electronic Prescribing Service (EPS)	*Repeat prescriptions can be sent electronically to the pharmacy of your choice. Paper prescriptions are less secure and slower, so we ask all our patients to sign for EPS – you go directly to the pharmacy to pick up your medicines. You can request repeat medicines online and we send them to the pharmacy, saving you time and trouble. You need to 'nominate' the pharmacy of your choice. You can change your nomination any time using the Patient App or asking at the surgery or chemist* .

Your EPS Consent

Please sign me up for EPS	☐	*I **DO NOT** want EPS*	☐
Name and address of pharmacy of your choice			

Information sharing Opt-Ins and Opt-Outs

Summary Care Record	*Click here for further information*

- Summary Care Records (SCR) are an electronic record of important patient information, created automatically through clinical systems in GP practices from medical records
- They can be seen and used by authorised staff in other areas of the health and care system involved in the patient's direct care
- SCR contains some basic information including regular medication and allergies and adverse medication reactions

You can OPT OUT of sharing your Summary Care Record with other health professionals (however this is very useful e.g. if you are incapacitated after an accident)

You can EXPRESS CONSENT FOR ADDITIONAL INFORMATION to be added, such as significant illnesses, vaccinations, personal care preferences and next of kin.

Click here more information and Opt In / Out form to email to the practice.

Opting Out Of Sharing Your Personal Health Information	*Click here for further information*

- Essential personal health information is shared between healthcare professionals when giving you personal medical care
- It is potentially dangerous to treat you without background information and this is why it is automatic
- There are strict rules around this sharing and you will be asked if you are happy to share at the point of care.

However, you can OPT OUT of sharing your personal health data for research and planning ('secondary use') by completing this NHS web-form

Organ donation Opt-out	*Click here for further information*

Organ donation is now automatic.

If you do NOT wish to donate any organs or tissue after death, you will need to OPT-OUT.

You can fill this NHS form to opt out