The Bartlett Group Practice

New Patient Questionnaire

Welcome to Bartlett Group Practice. Can you please complete the following questionnaire? If you are taking regular medication you may need to see a doctor before a prescription can be issued. **Please bring a copy of your latest prescription or your medicines with you** so that the doctor can see what medication you are currently prescribed.

Personal Details:								
Title:	First Name:				Surname:			
DOB:	Home Tel:				Mobile Tel:			
Email:					Occupation:			
Military Veteran?	Army		RAF		RM		RN	

Next of Kin – Name and Address	Emergency contact Details	Consent for medical details to be discussed
Mr/Mrs/Ms:	Tel:	Yes/No:
What relationship is the Next of kin to the patient?		

Height:			Weight:		
Smoking:	Cigarette		Would you like stop smoking advice?		
	Pipe		YES		NO
	Never		Exercise:	Exercise impossible	
	Ex Smoker			Light exercise	
	Current			Moderate exercise	
Amount per day?				Vigorous exercise	

Ethnicity:									
White/British		Mixed		Asian/Asian British		Black/Black British		Chinese	
Irish		White/Black Caribbean		Indian		Caribbean		Other ethnicity	
Other White		White/Black African		Pakistani		African		Do not wish to state	
		White/Asian		Bangladeshi		Other Black			
		Other mixed		Other Asian					

Allergies: Have you had any allergies (to drugs or other materials)?	
Which drug/material?	
How severe?	
Please state details:	

Most recent Immunisations: (dates if you have this information)					
Tetanus		Rubella		Pneumoccus	
Polio		Hepatitis B		Other	

Family History: Please tick if your parents have suffered from any of the following-												
Father	Heart Attack/Angina		High BP		Stroke		Asthma		Diabetes		Cancer	
Mother	Heart Attack/Angina		High BP		Stroke		Asthma		Diabetes		Cancer	
Grandfather	Heart Attack/Angina		High BP		Stroke		Asthma		Diabetes		Cancer	
Grandmother	Heart Attack/Angina		High BP		Stroke		Asthma		Diabetes		Cancer	

Medical History: List any illnesses that you have with dates if possible	
Illness	**Date of diagnosis**
List any important operations that you have had with dates if possible.	
Operation	**Date**

Women only					
Do you take any form of contraception?	Yes/No		Type		
When did you have your last breast screen?				What was the result?	
When was your last cervical smear?				What was the result?	

Prescribed Drugs and Medicines: Please state below any medicines (including the contraceptive pill) prescribed for you by your GP, or provide a copy of a previous prescription.		
Name and strength of medicine	How often taken	Date started
To enable electronic prescribing please nominate which pharmacy you would prefer to collect your medication from.		

Zero Tolerance Policy	
I have read, understood and accept the Practice Zero Tolerance Policy	
Signature	

Alcohol Use						
It is a government priority to address the issue of illness associated with alcohol consumption. Please complete the following short questionnaire as part of the New Patient Registration Process.						
Please state alcohol Consumption: *One unit = ½ pint of beer/lager, 1 shot measure of spirits, 1 small glass wine*				**Number of alcohol units per week?**		
Alcohol Users Disorders Identification Test (AUDIT) C						
Questions	**Scoring system**					**Your Score**
	0	1	2	3	4	
How often do you have a drink that contains alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	0-2	3-4	5-6	7-9	10+	
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	
Scoring: A total of 5+ indicates hazardous or harmful drinking - An overall total score of 5 or above is AUDIT-C positive						

Carer Information:		
Do you have a carer?	Yes/No	
If Yes, please complete	Details of carer	
Name Address		
Telephone		
Relationship to patient (if any)		
May we share your information with your carer?	Yes/No	
Do you look after someone who could not manage without you?	Yes/No	
If Yes, please complete Name Address	Details of person you care for	
Telephone		
Relationship to patient (if any)		
Why do you care for them?		

Communication Needs			
What is your first Language?		Do You require an Interpreter?	
Do you have any communication/information needs relating to a disability, impairment or sensory loss, and if so, what are they? (e.g. sight, hearing, learning)			
I consent to be contacted by ticked forms of communication.	Letter/Large print letter (please delete)		
Signature:	email		
	Telephone		
	SMS		

Summary Care Record:

This practice has started the national Summary Care Record programme which enables each patient to have a summary of their key medical information held securely on the NHS central database, known as the NHS Spine. This summary record could be used in an emergency if you needed treatment when access to the medical record held by your GP was not available; for example if you call the doctor out of hours. You will always be asked to give permission for this record to be viewed and you have the right to decline. Please indicate below whether you would like to have your own Summary Care record by indicating your decision. A full explanation of each choice follows.

My Decision	**Tick ONE**
1. I wish to have a Summary Care record containing my medications, allergies and adverse reactions or sensitivities to medications. (9Ndm)	
2. I wish to have a Summary Care record with the above plus additional important medical information held on my record. (9Ndn)	
3. I do not wish to have a Summary Care record (9Ndo)	

1. A Summary Care record will be created for you from the details held on our GP clinical system and will contain:

   a. any record we have of your current repeat medication, any acute medication (one-offs e.g. antibiotics) and any recently discontinued medication.

   b. Any record we have of adverse reactions to medication

   c. Any record we have of your allergies

2. A Summary Care record will be created for you containing the details itemised above in 1. PLUS important additional information you and your GP agree would be useful (e.g. Diagnoses – Asthma, Diabetes etc; Pacemaker, End of life care etc) Please discuss this with your GP practice at your next visit.

3. A note will be made in your records that you do not wish to have a Summary Care record. Please note that if you attend A&E or if you need emergency treatment when the GP practice is closed the clinicians treating you may not have access to key information to help them give you the most appropriate treatment.

For further information call NHS Digital on: 0300 303 5678 or visit https://www.digital.nhs.uk/summary-care-records/patients

Signed	**Date**

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

Name	**Parent**	**Legal Guardian**	**Lasting power of attorney for health and welfare**

For internal use only						
Registration Forms checked						
Mandatory signature checked	GMS1		Zero Tolerance		SCR	
Address validation	Type		Official No.			
ID checked	Type		Official No.			