GROVE MEDICAL PRACTICE

Data Protection Act New patient Questionnaire– Appendix 1 to Annex M

Contact Details

Title ……..

Surname ……..

First Names ……

Previous Surnames ……..

Home Address

Postcode

Date of Birth ……

Home Tel …….

Mobile Number …….....

Email Address ……

Profession/Occupation …….

Can we contact you by Text Message?
☐ Yes ☐ No

Can we contact you by email?
☐ Yes ☐ No

Information about you

Have you been registered at this practice before?
☐ Yes ☐ No

Do you require an interpreter?
☐ Yes ☐ No

What is your main language…….

Do you have any communication needs?
☐ Yes ☐ No

If yes, what are these needs?

☐ Braille ☐ Audio ☐ Other (please state)
☐ BSL ☐ Large Print

Height (approx.)

…….ft…….in or ……..m

Weight (approx.)

…….st……lb or ……kg

Which of the following best describes how you think of yourself?

A: White
☐ British
☐ Irish
☐ Any other White background (Please Write in)

B: Mixed
☐ White and Black Caribbean
☐ White and Black African
☐ White and Asian
☐ Any Other mixed background (Please write in)

C: Asian or Asian British
☐ Indian
☐ Pakistani
☐ Bangladeshi
☐ Any other Asian background (Please write in)

D: Black or Black British
☐ Caribbean
☐ African
☐ Any other Black background (Please write in)

E: Chinese or other Ethnic Group
☐ Chinese
☐ Any other (Please write in)

☐ Not stated

Which of the following best describes how you think of yourself?

- ☐ Woman (including trans woman)
- ☐ Man (including trans man)
- ☐ Non-binary
- ☐ In another way (please state)

……..

Is your gender identity the same as you were given at birth?

☐ Yes ☐ No

Which of the following best describes how you think of yourself?

- ☐ Lesbian / Gay
- ☐ Heterosexual/Straight
- ☐ Bisexual
- ☐ In another way (please state)

What is your employment status?
Please tick all options that apply

- ☐ Employed (full time)
- ☐ Employed (part time)
- ☐ Student (full time)
- ☐ Student (part time)
- ☐ Unemployed
- ☐ Retired

Are you are carer?
(A carer is *someone who provides unpaid care for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support*)

☐ Yes ☐ No

If yes, who do you care for?

……...

Are you permanently housebound?

☐ Yes ☐ No
If you find it necessary to request a home visit we would be grateful if you could contact us before 10.30am

Have you ever served in the military?

☐ Yes ☐ No
If Yes which service?

Have you registered for Electronic Prescription Services (EPS)?

☐ Yes ☐ No

If yes which pharmacy have you nominated/would like to nominate?

……...

Please remember that you may need to update your nominated pharmacy if you are moving into the area. This can be done by visiting your pharmacy of choice.

Medication , Family History & Lifestyle

Do you take regular repeat medication?
☐ Yes ☐ No

If yes please attach a printout of your repeat medication from your previous GP Practice

Are you allergic to any medication?
☐ Yes ☐ No

Please state…….

Have you ever suffered from? (tick as appropriate)

- ☐ Epilepsy
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Heart attack/Stroke
- ☐ Asthma
- ☐ Mental Health
- ☐ COPD
- ☐ Diabetes
- ☐ Depression
- ☐ Blindness/Glaucoma
- ☐ Other ……

……
……

Do you have a family history of any of the following? If yes please detail family member(s) age and relation to you:

☐ Diabetes ……
☐ Epilepsy……
☐ Stroke……
☐ Asthma……...
☐ Breast Cancer……...
☐ High Blood Pressure……
☐ Heart Disease……...

Have you had any significant operations?

☐ Yes ☐ No

Please give details:

Are you living with HIV?

☐ Yes ☐ No
☐ I don't know/unsure

Date of last cervical smear:

Do you enjoy?

☐ Heavy Exercise ☐ Light Exercise

☐ Moderate Exercise ☐ Exercise is impossible

What is your smoking status?

☐ Current smoker ☐ Ex-smoker

How many per day …….

☐ Never smoked

Your Data Matters to the NHS

Information about your health and care helps us to improve your individual care, speed up diagnosis, plan your local services and research new treatments.

In May 2018, the strict rules about how this data can and cannot be used were strengthened. The NHS is committed to keeping patient information safe and always being clear about how it is used.

You can choose whether your confidential patient information is used for research and planning

To find out more visit : **nhs.uk/your-nhs-data-matters** or call **0300 303 5678**

You can change your choice at any time

Online Services

Would you like to register for on line services so you can:

- ☐ Book & Cancel Appointments online
- ☐ Order Repeat Medication online
- ☐ View aspects of your medical record

Name: _____

Signature: _____

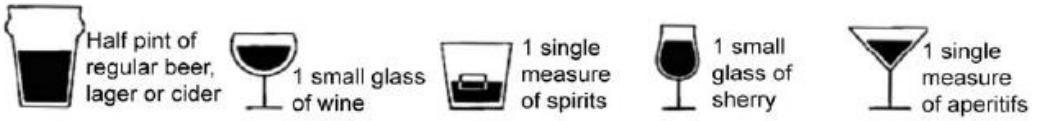
Date: _____

Creation date – 25th May 2018
Creator – Practice Manager
Deputy – Lead GP
Review – Two Yearly
Last Review – 31st January 2019

Please turn over to complete this questionnaire

AUDIT – C – Part One

This is one unit of alcohol…



…and each of these is more than one unit

How many units of alcohol do you consume in a week?……

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing 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?	1 -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 increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

If your Audit C score is 5 or over please complete the next section

AUDIT – C – Part Two

Questions	Scoring system					Your score
	0	1	2	3	4	
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	
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	
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	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence

SCORE B

Name: _____

Signature: _____

Date: _____

TOTAL Score equals
Score A (Previous Page) +
Score B (This page)

TOTAL