Lonsdale Medical Centre

New Patient Questionnaire

Please complete this form as accurately as possible and book an appointment for a New Patient check if you would like one. Please note that some form of identification will be requested.

Name

Date of Birth

Telephone (home)

Telephone (work)
Mobile number

Marital status

Email address

Medical History

Indicate below if YOU have suffered from any of the following:

Indicate below if A CLOSE RELATIVE (e.g. Parent/ Sibling/Uncle/Aunt**) has had any of the following:**

	Approx date of first diagnosis	Details / current severity etc.	Please state which relative	Age at which diagnosed
Asthma (H33..)/Breathing problems (COPD = H3…)				
Blood Pressure (G2…)				
Cancer (B…. then select)				
Stroke/thrombosis (G6…then select)				
Diabetes (C108. or C109.)				
Heart Disease (G3… then select)				
Depression /mental health Please use ISIS)				
Hypothyroidism (C04..)				
Epilepsy (F25..)				
Other problems, operations, accidents, major illnesses.				

Allergies (if any):

Medication: Please give details of your current drug therapy (including oral contraception.)

Name	Strength	Daily Dose

ALCOHOL SCREENING QUESTIONNAIRE	**How many units per week do you drink?** (1unit = ½ pt beer/cider or 1 glass sherry/wine, 1 single measure of spirits)					_____ **Units/week**
Questions	**Scoring System**					**Your score**
	0	1	2	3	4	
Men: How often do you have **8** or more drinks on one occasion? **Women:** How often do you have **6** or more drinks on one occasion?		Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	
	If your score is over 3, PLEASE COMPLETE THE ATTACHED QUESTIONNAIRE				Total	

Smoking History

Have you ever smoked? Yes No

If you have given up smoking when did you stop?

If yes, what did / do you smoke? Cigarettes Roll-ups Pipe Cigars

For how long were you a smoker?

If you still smoke how many do you smoke a day?

Height: **Weight:**

Exercise

How many times a week do you exercise and what type of exercise?

Vaccinations (please enter dates where possible)

Tetanus Hepatitis A Meningitis C
Typhoid Other Polio

Carers

Do you look after or support someone who is ill, frail, disabled or mentally ill?

- ☐ Yes - If you would like to be referred to Carer's First please notify Reception.
- ☐ No

Women only

Details of pregnancies

Current contraceptive method (if applicable)

Date and result of last smear:

Signature _____ Date _____

Please could you answer the questions below regarding your use of alcoholic beverages during this past year. Examples of these beverages are beer, wine, vodka etc. Please enter the correct answer number in the box at the right

1. How often do you have a drink containing alcohol? (0) Never [Skip to Qs 9 – 10] (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week	6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
2. How many drinks containing alcohol do you have on a typical day when you are drinking? (0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7, 8 or 9 (4) 10 or more	7. How often during the last year have you had a feeling of guilt or remorse after drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
3. How often do you have 6 or more drinks on one occasion? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily *Skip to Question 9 and 10 if Total Score for Questions 2 and 3 = 0*	8. How often during the last year have you been unable to remember what happened the night before because you had been drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily	9. Have you or someone else been injured as a result of your drinking? (0) No (2) Yes, but not in the last year (4) Yes, during the last year
5. How often during the last year have you failed to do what was normally expected from you because of drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily	10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

If your score is more than 8 please can you make a routine appointment with the nurse and let reception know the reference 'audit c'

Recording ethnicity

We are asking every new patient about his or her *ethnic group*. This is different from *nationality*. For example, some of our patients who have British nationality may have a different *ethnic category*, such as Irish, Caribbean or African.

The Department of Health has asked doctors' surgeries to collect this information as it helps us to identify who might be at greater risk from conditions such as heart disease, diabetes or kidney disease. This enables us provide better care for you.

We use the same ethnic group categories as the 2001 national census. The data we collect is held on a strictly confidential basis and is covered by the 1996 Data Protection Act.

Please circle the code for the group that you think is most appropriate for you.

WHITE:-	CODE	BLACK OR BLACK BRITISH:-	CODE
White British	9S10.	Caribbean	*9S2..*
White Irish	9S11.	African	9S3..
Any other White background	9S12.	Any other black background	9SG..
MIXED:-		OTHER ETHNIC GROUPS:-	
White and Black Caribbean	9SB5.	Chinese	9S9..
White and Black African	9SB6.	Any other ethnic group	9SJ..
White and Asian	9SB2.		
Any other mixed background	9SB..		
ASIAN OR ASIAN BRITISH		NOT STATED	
Indian	9S6..	I don't wish to give ethnicity	9SD..
Pakistani	9S7..		
Bangladeshi	9S8..		
Any other Asian background	9SH..		

Surname……..

Forename(s) ……..

Date of Birth (DD/MM/YYYY) …….

Telephone Number …….

ADMINISTRATION ONLY:

Identitiy (please specify) checked ……...administrator's initials

Residency (please specify) checked ……administrator's initials

Visa (if required) checked……administrator's initials

Patient Care Messaging Service

Declaration of Consent/Decline Form

Lonsdale Medical Centre has introduced the sending of SMS text messages to your mobile phone to remind you of any appointments that you have booked at the surgery. We are also asking permission to leave a message on your landline about a change of appointment.

The SMS text service should not be solely relied upon; the responsibility of attending appointments or cancelling them still rests with you.

The text messages are generated using a secure system, however, they are transmitted over a public network on to a personal telephone and as such may not be secure. The practice will not transmit any information that would enable an individual patient to be identified. At this time the surgery does not offer a reply facility to enable patients to respond to texts directly.

Please tick as appropriate:

I Consent to the practice contacting me by text message for the purposes of appointment reminders or change of appointment. (9NdP) ☐

I Consent to the practice leaving messages on my landline for the purposes of appointment reminders or change of appointment. (9Ndi) ☐

I Decline to the practice contacting me by text message for the purposes of appointment reminders or change of appointment. (9NdQ) ☐

I Decline to the practice leaving messages on my landline for the purposes of appointment reminders or change of appointment. (9Ndv) ☐

I also agree to advise the practice if my landline number or mobile number changes or if the telephone numbers are no longer in my name so that my records can be kept up to date. ☐

The SMS service may be used as a reminder to book in for a flu clinic or other clinics. In the future we may also send texts to inform you that your test results are available, but texts would not contain any personal details or personal information within the message. You can cancel the text message facility at any time.

Patient Name……
Mobile Number to be Used …….
Date of Birth ……..... Date …….

PTO

Supplementary Patient Questionnaire for PATIENTS ENTERING THE UK FROM ABROAD	
Name: Date of birth:	Address:

Have you provided any of the following means of identification? (Please tick)		
Birth certificate Marriage certificate Medical card	Bank cards/ statements National insurance no card Driving licence Passport	Wage slip Evidence of benefit entitlement Local authority rent card Paid utility bills
Please give your country of origin		
Please give the date you entered the UK.		
Do you have any medical insurance cover?		
Is this the first time you have asked to register with a doctor in the UK?		
Do you expect to be resident in the UK for more than 6 months? If so, for how long?		
Do you have a permanent address in Tunbridge Wells?		
Do you have any relatives already registered with us?		
Do you need a translator to help explain any medical problems?		

You may obtain more information about medical treatment for overseas visitors by going to the Department of Health website: www.dh.gov.uk/PolicyAndGuidance/HealthAdviceForTravellers/fs/en

Summary Care Record

The summary care record (SCR) is a secure, electronic patient record containing key information from a patient's record: a list of medications, allergies and adverse reactions. The SCR is accessed in situations where such information would otherwise be unavailable, such as when you attend a hospital or the out of hours doctor service. It also works well for the holidaymaker who has left medications at home. Clinicians can request to view the content of the SCR, helping patients at a vulnerable time. Patients are automatically opted into this service. If you do not want your key information available to other clinicians, please tick the following box.

I decline the summary care record upload. (9Ndo) ☐

Sharing Your Health Information with a Family Member / Carer / Friend

If you want another person close to you to be able to request prescriptions, request test results or discuss your health problems at the surgery please give details below. (9NdG)

Your Name		
Name of person with whom you would like to share your health information.	Relationship to you (eg. Partner, daughter, friend etc)	Comments / other details (eg. Contact telephone no.)
Mr/Mrs/Ms/Miss		

I consent to the above named person sharing my health information. I will notify the surgery if I wish to withdraw this consent.

Is the above named person:

Next of kin Yes ☐ No ☐
An Emergency contact Yes ☐ No ☐

EPS (Electronic Prescription Service)

PLEASE NOMINATE A CHEMIST FOR YOUR PRESCRIPTION TO GO TO ELECTRONICALLY FROM THE SURGERY WHEN REQUESTED.

PHARMACY ……

Signature ……

Date …….