

For staff use only

| EPS Nomination Canceled | ID confirmed | Address confirmed | Named Dr | Informed of named Dr |
|-------------------------|--------------|-------------------|----------|----------------------|
| | | | | |

Dapdune House Surgery New Patient Questionnaire

This form is for the registration of patients of 11 years and over

Please complete as many questions as you can. Some questions may not apply to you. You are under no obligation to complete this form but your medical records may take several months to reach us, and the information you give us will assist us in providing you with good medical care.

Any information you give is confidential.

Personal Details

| | | | | | | | |
|---------------------------------|--|-------------------------------------|----------------------------------|--|--|----------------------------------|---|
| Title | Mr. <input type="checkbox"/> | Mrs. <input type="checkbox"/> | Miss <input type="checkbox"/> | Ms. <input type="checkbox"/> | Dr. <input type="checkbox"/> | Rev. <input type="checkbox"/> | Other <input style="width: 50px;" type="text"/> |
| Names | Surname <input style="width: 90%; height: 20px;" type="text"/> | | | | | | |
| | Previous Surname (if applicable) <input style="width: 90%; height: 20px;" type="text"/> | | | | | | |
| | Forename(s) <input style="width: 90%; height: 20px;" type="text"/> | | | | | | |
| | Usual Forename <input style="width: 90%; height: 20px;" type="text"/> | | | | | | |
| Marital Status | Single <input type="checkbox"/> | Cohabiting <input type="checkbox"/> | Married <input type="checkbox"/> | Separated <input type="checkbox"/> | Divorced <input type="checkbox"/> | Widowed <input type="checkbox"/> | |
| Date of Birth | <input style="width: 150px; height: 20px;" type="text"/> | | | Occupation | <input style="width: 150px; height: 20px;" type="text"/> | | |
| Place of Birth | <input style="width: 90%; height: 20px;" type="text"/> | | | | | | |
| Current Address | <input style="width: 90%; height: 20px;" type="text"/> | | | | | | |
| | <input style="width: 90%; height: 20px;" type="text"/> | | | | | | |
| | Postcode | | | | | | |
| | Telephone (Home) | | | <input style="width: 80%; height: 20px;" type="text"/> | | | |
| | Telephone (Mobile) | | | <input style="width: 80%; height: 20px;" type="text"/> | | | |
| | Telephone (Work) | | | <input style="width: 80%; height: 20px;" type="text"/> | | | |
| E-Mail Address | <input style="width: 90%; height: 20px;" type="text"/> | | | | | | |
| Previous Address | <input style="width: 90%; height: 20px;" type="text"/> | | | | | | |
| | <input style="width: 90%; height: 20px;" type="text"/> | | | | | | |
| | Postcode | | | | | | |
| Next of Kin - Title/Name | <input style="width: 90%; height: 20px;" type="text"/> | | | | | | |
| Address | <input style="width: 90%; height: 20px;" type="text"/> | | | | | | |
| | <input style="width: 90%; height: 20px;" type="text"/> | | | | | | |
| Telephone (Home) | <input style="width: 90%; height: 20px;" type="text"/> | | | | | | |
| Relationship to Patient | <input style="width: 90%; height: 20px;" type="text"/> | | | | | | |

Ethnic Group

| | | | | | | | | |
|-------------------------------|--------------------------|------------------------|--------------------------------|--------------------------|-------------------------|---|--------------------------|------------------------|
| White | | | Mixed | | | Asian or Black Asian | | |
| A | <input type="checkbox"/> | British | D | <input type="checkbox"/> | White & Black Caribbean | H | <input type="checkbox"/> | Indian |
| B | <input type="checkbox"/> | Irish | E | <input type="checkbox"/> | White & Black African | I | <input type="checkbox"/> | Pakistani |
| C | <input type="checkbox"/> | Other white background | F | <input type="checkbox"/> | White & Asian | J | <input type="checkbox"/> | Bangladeshi |
| | | | G | <input type="checkbox"/> | Other mixed background | K | <input type="checkbox"/> | Other Asian background |
| Black or Black British | | | Other Ethnic Categories | | | | | |
| L | <input type="checkbox"/> | Caribbean | O | <input type="checkbox"/> | Chinese | Any other Ethnic category – please state below: | | |
| M | <input type="checkbox"/> | African | | | | | | |
| N | <input type="checkbox"/> | Other black background | P | <input type="text"/> | | | | |

Lifestyle

Tobacco consumption

| | | | | | | | |
|--------------|--------------------------|-------------|--------------------------|--------------------|--------------------------|--------------------|--------------------------|
| Never Smoked | <input type="checkbox"/> | Pipe Smoker | <input type="checkbox"/> | Smoker | <input type="checkbox"/> | Ex-Smoker | <input type="checkbox"/> |
| | | Oz. per day | <input type="text"/> | | | Year Stopped | <input type="text"/> |
| | | | | Less than 1 a day | <input type="checkbox"/> | Less than 1 a day | <input type="checkbox"/> |
| | | | | 1-9 a day | <input type="checkbox"/> | 1-9 a day | <input type="checkbox"/> |
| | | | | 10-19 a day | <input type="checkbox"/> | 10-19 a day | <input type="checkbox"/> |
| | | | | 20-39 a day | <input type="checkbox"/> | 20-39 a day | <input type="checkbox"/> |
| | | | | More than 40 a day | <input type="checkbox"/> | More than 40 a day | <input type="checkbox"/> |

Free NHS Stop Smoking Service on 0845 602 3608 or ask @ Dapdune Pharmacy

Body Mass

| | | | | | |
|--------|----------------------|--------|----------------------|---------------------|----------------------|
| Height | <input type="text"/> | Weight | <input type="text"/> | Waist circumference | <input type="text"/> |
|--------|----------------------|--------|----------------------|---------------------|----------------------|

Alcohol consumption

| | | | | | | | |
|-----|--------------------------|--------------------|--------------------------|--------------------|--------------------------|---------------------------|--------------------------|
| Nil | <input type="checkbox"/> | Occasional | <input type="checkbox"/> | 1-7 Units a week | <input type="checkbox"/> | 8-14 Units a week | <input type="checkbox"/> |
| | | 15-21 Units a week | <input type="checkbox"/> | 22-35 Units a week | <input type="checkbox"/> | 36-49 Units a week | <input type="checkbox"/> |
| | | | | | | More than 50 Units a week | <input type="checkbox"/> |

One unit = 1/2 pint of beer/lager, 1 shot measure of spirits, 1 small glass of wine

Exercise

| | | | | | | | |
|---------------------|--------------------------|----------------|--------------------------|-------------------|--------------------------|-------------------|--------------------------|
| Exercise impossible | <input type="checkbox"/> | Light exercise | <input type="checkbox"/> | Moderate exercise | <input type="checkbox"/> | Vigorous exercise | <input type="checkbox"/> |
| In what form? | <input type="text"/> | | | | | | |

Disabilities

Are you housebound? Yes No

Do you suffer from severe hearing loss? Yes No

Are you Registered Blind? Yes No

Do you suffer from learning disabilities Yes No

Do you have any information or communication support needs relating to disability, impairment or sensory loss Yes No

Allergies

Have you had any allergies (to drugs or other materials)? Yes No

Which drug/material?

How severe?

Please state details

Veteran Status

| | | | | |
|-------------------------------------|----------------------|--------------------------|-----------|--------------------------|
| Are you Ex-Armed forces | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Please indicate your service | <input type="text"/> | | | |

Practice Booklet

If you would like to receive a practice booklet, please ask at reception or indicate below and one will be emailed to you if you have given an Email address on registration.

Please email me a copy of your practice booklet

The Alcohol Use Disorder Identification Test: Self-Report Version

Because alcohol use can affect your health and can interfere with certain medications and treatments. It is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. **Please fill in this questionnaire if you are 16 years or older.**

Place an 'X' (cross) in one box that best describes your answer to each question.

| Questions | 0 | 1 | 2 | 3 | 4 | |
|--|----------|-------------------|-------------------------------|------------------|---------------------------|--|
| 1. How often do you have a drink containing alcohol? | Never | Monthly or less | 2-4 times a month | 2-3 times a week | 4 or more times a week | |
| 2. How many drinks containing alcohol do you have on a typical day when you are drinking? | 1 or 2 | 3 or 4 | 5 or 6 | 7 to 9 | 10 or more | |
| 3. How often do you have six or more drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | 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? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| 5. How often during the last year have you failed to do what was normally expected of you because of drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| 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? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| 7. 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 | |
| 8. How often during the last year have you been unable to remember what happened the night before because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| 9. Have you or someone else been injured because of your drinking? | No | | Yes, but not in the last year | | Yes, during the last year | |
| 10. Has a relative, friend, doctor, or other health care worker been concerned about the drinking or suggested you cut down? | No | | Yes, but not in the last year | | Yes, during the last year | |
| | | | | | Total | |

Do you wish to opt-out of receiving: SMS text messages? Yes e-mail? Yes

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 below. 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.**
- 2. **I wish to have a Summary Care record with the above plus additional important medical information held on my record.**
- 3. **I do not wish to have a Summary Care record.**

- 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.

Signed

Date

