**For staff use only:**
NPQ taken in by: _____ Date taken in: _____ Is Patient a Student: Y/N

ID details: _____ Address confirmed ☐ Named GP & Informed ☐

**GMS1 checklist**:

Signed & Dated ☐ Previous Address & GP ☐ If not previously registered within UK date of entry ☐

Date of entry less than 6 months reverse to be **fully** completed ☐

# 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. | | Mrs. | | Miss | | Ms. | | Dr. | | Rev. | | Other |
| **Names** | **Surname** | | | | | | | | | | | | |
| | **Previous Surname (if applicable)** | | | | | | | | | | | | |
| | **Forename(s)** | | | | | | | | | | | | |
| | **Usual Forename** | | | | | | | | | | | | |
| **Marital Status** | Single | | Cohabiting | | Married | | Separated | | Divorced | | Widowed | | |
| **Date of Birth** | | | **Occupation** | | | | | | | | | | |
| **Place of Birth** | | | | | | | | | | | | | |
| **Current Address** | | | | | | | | | | | | | |
| | Postcode | | | | | | | | | | | | |
| | **Telephone (Home)** | | | | | | | | | | | | |
| | **Telephone (Mobile)** | | | | | | | | | | | | |
| | **Telephone (Work)** | | | | | | | | | | | | |
| | **E-Mail Address** | | | | | | | | | | | | |
| **Previous Address** | | | | | | | | | | | | | |
| | Postcode | | | | | | | | | | | | |

| | | |
|---|---|---|
| **Next of Kin - Title/Name** | | |
| **Address** | | |
| | Postcode | |
| **Telephone** | | |
| **Relationship to Patient** | | |

# Ethnic Group

| White | | Mixed | | Asian or Black Asian | |
|---|---|---|---|---|---|
| A | British | D | White & Black Caribbean | H | Indian |
| B | Irish | E | White & Black African | I | Pakistani |
| C | Other white background | F | White & Asian | J | Bangladeshi |
| | | G | Other mixed background | K | Other Asian background |

| Black or Black British | | Other Ethnic Categories | |
|---|---|---|---|
| L | Caribbean | O | Chinese |
| M | African | | Any other Ethnic category – please state below: |
| N | Other black background | P | |

# Lifestyle

## Tobacco consumption

| Never Smoked | Pipe Smoker | Smoker | Ex-Smoker |
|---|---|---|---|
| | Oz. per day | | Year Stopped |
| | | Less than 1 a day | Less than 1 a day |
| | | 1-9 a day | 1-9 a day |
| | | 10-19 a day | 10-19 a day |
| | | 20-39 a day | 20-39 a day |
| | | More than 40 a day | More than 40 a day |

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

## Body Mass

Height | Weight | Waist circumference

## Alcohol consumption

| Nil | Occasional | 1-7 Units a week | 8-14 Units a week |
|---|---|---|---|
| | 15-21 Units a week | 22-35 Units a week | 36-49 Units a week |
| | | | More than 50 Units a week |

***One unit = ½ pint of beer/lager, 1 shot measure of spirits, 1 small glass of wine***

## Exercise

Exercise impossible | Light exercise | Moderate exercise | Vigorous exercise

In what form?

## 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 | | No | |
| Please indicate your service | | | | |

## Practice Booklet

If you would like to recive 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** | |

| | ***Opt IN*** | ***Opt OUT*** |
|---|---|---|
| We may contact you on occations by **SMS** to remind you of appts, confirm appts, invite you to complete surveys, update you on practice business and other health care related topics. Please opti or opt out | | |
| We may contact you on occations by **EMAIL** to remind you of appts, confirm appts, invite you to complete surveys, update you on practice business and other health care related topics. Please opti or opt out | | |

***You may Opt in or out at any time by informing the practice or replying Opt OUT/In to SMS messages***

## *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***