Trinity & Bowthorpe Medical Practice
New Patient Questionnaire

Welcome to The Trinity & Bowthorpe Medical Practice.
To register with our practice please complete this questionnaire as fully as possible.
It can take a while for your medical records to reach the practice therefore the information you provide now will help the clinicians should you need to be seen whilst we await your records.

Have you been registered with this surgery before? Yes ☐ No ☐

PERSONAL DETAILS:					
Title:		Address:			
Forename:					
Surname:					
Date of Birth:				Post Code:	
Occupation:		Marital Status:			
Home Tel No:		Work Tel No:			
Mobile Tel No:					
Would you like to receive text message appointment reminders and other notices? **– Please inform us if your contact details change at any time**	Yes		No		
Email Address:					
By suppling us with an email address you consent to us sending you any correspondence in the future via E-Mail					
What is your preferred method for us to contact you?	Letter		Text Message		E-mail
Online Services:					
This will enable you to book appointments/cancel appointments, order repeat medication and update any contact details for yourself. You can only apply for yourself and you must be aged over 16. ***Photographic ID is required.*** *For access for under 16's please ask at reception.*					
Would you like to be registered for online services?	Yes:		No:		If yes, please sign below.
Signature:		Date:			
Next Of Kin - An Emergency Contact:					
Name:		Relation to you?			
Their Address:		Home Telephone:			
		Mobile Telephone:			
		Their Postcode:			
Is your Next of Kin registered at this practice?	Yes		No		
Carer:					
Are you an informal carer? (do you care for a family member or friend)	Yes		No		
If you are please give details of the person you are caring for: **(Their name, address, postcode and if they are a relation to you)**					
Do you have a carer?	Yes		No		
If you do please give details of the person that is caring for: **(Their name, address, postcode and if they are a relation to you)**					
If you are a carer, do you have a carers booklet?	Yes:		No:		

Health Details:			
Height:		Weight:	

Smoking Status (**please tick**):	Smoker		Ex-smoker		Never smoked		
How many cigarettes do you smoke in a day?		How many years have you smoked?					
If you are an ex-smoker, when did you give up?							
What is your average weekly alcohol intake in units? **(1 unit = ½ pint of beer or 1 glass of wine or 1 measure of spirits)**							

Questions	**Scoring scheme**					**Enter score below**
	0	1	2	3	4	
1. How often do you have 8 (for a man) 6 (for a woman) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only consider questions 2, 3 and 4 if the response to question 1 is less than monthly or monthly						
2. 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	
3. How often during the last year have you failed to do what is normally expected of you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. In the last year has a relative/friend or a doctor/health worker been concerned about your drinking or suggested you cut down?	No		Yes, on one occasion		Yes, on more than one occasion	
					Total:	

Military Veterans:			
Have you previously served in any of the military services?	Yes		No
If yes please state the date you were discharged?			
Are you content that this is annotated on your medical record?	Yes		No

Ethnicity:							
White:	British		Irish		Other White Background		
Black or Black British:	Caribbean		African		Other Black Background		
White & Black Caribbean		White & Black African		White & Asian		Other Mixed Background	
Indian		Pakistani		Bangladeshi		Other Asian Background	
Chinese		Arab		Decline to state ethnicity			
Other (Please specify)							

Language:			
Is English your first spoken language?	Yes		No
If No please state your main spoken language:			
Do you require a translator when you visit the surgery?	Yes		No

Women Only:			
Are you currently pregnant?	Yes		No
If Yes, please state how many weeks you are:		Please enter your EDD if known:	

Have you ever had a cervical smear?	Yes		No			
If you have please state the date you last had one done?						
Have you had a hysterectomy?	Yes		No		If yes, what year:	

Contraception - what do you currently use (please tick which one applies)					
Contraceptive Pill		Implant		Injection	
Condom		Coil		Hysterectomy	
Sterilisation		Partner had vasectomy		None	

Sharing Preferences:

Summary Care Record – your emergency care summary:

The record will contain information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had to ensure those caring for you have enough information to treat you safely. Also, if you specifically choose to do so, your Summary Care Record can hold other information you have agreed with your GP Practice to have included.

Your Summary Care Record will be available to authorised healthcare staff providing your care anywhere in England, but they will ask your permission before they look at it. This means that if you have an accident or become ill, the doctors treating you will have immediate access to important information about your health.

If you do not want a Summary Care Record created for you, please complete an Opt Out form (available from Reception). If you do not complete an Opt Out form a Summary Care Record will automatically be created.

Enhanced Data Sharing:

If you are filling out this form on behalf of another person or a child, provide your details here

Your name..... Your signature.....

Relationship to patient ..... Date .....

Sharing out from this service	**Please tick one box**
YES I would like to make information recorded at this service sharable to other services caring for me	
NO I would not like to make information recorded at this service sharable to other services caring for me	
Sharing in to this service	**Please tick one box**
YES I would like this service to be able to view information recorded at other services caring for me that I have made sharable	
NO I would not like this service to be able to view information recorded at other services caring for me that I have made sharable	

I have read and understood the leaflet '**Your electronic patient record and the sharing of information**'

Please Note:

- Information is recorded about you at each service where you receive care and treatment.
- All information recorded about you is done so with the strictest of confidence and that any access to your electronic records is fully auditable.
- NHS staff can only access shared information if you are receiving care from them.
- Staff access is controlled with a Smart Card using 'chip and pin' security.
- You can request certain items to be marked as 'private' and these items will not be shared.
- Sharing in this way is only available where services use the same computer system
- There is a difference between a Summary Care Record, which only holds limited information about you but can be viewed by any Urgent/Emergency NHS service where you need to be seen anywhere in the country using any IT system, your Detailed Care Record, which holds all information recorded about you can only be viewed by services that use the same computer system where you are receiving care.

Allergies – Please state what allergies you have if known	
Drug Allergies	
Food Allergies	
Any other allergies	

Medication:

If you have regular medication on a repeat prescription please try and supply us with a repeat slip, if you don't have a slip please give us details of your medicines below:

Name of Drug:	**How often do you take?**	**Reason for using this medication**	**When did you last get this item on repeat?**

Prescriptions:

	I would like my prescriptions to go electronically to a pharmacy.
Please state which pharmacy you would like us to send your prescriptions too.	
	I would like to collect my future prescriptions from the surgery.

Medical Conditions:

Do you have any serious health problems/long term conditions?	Yes		No	
If yes, please specify.				

Accessible Information:

Do you require help with information? **(e.g. different formats, Braille, email, large print, sign language etc.)**	Yes		No	
If Yes, please give details here:				

Family History: (please state which family member)

Asthma		Stroke	
Diabetes **Please state if type 1 or 2**		Heart disease	
High Blood Pressure		Cancer	
Any Other Illness		No relevant family history	

Hospital Care:

Are you currently under hospital care?	Yes		No	
If yes, please specify, which department and the nature of your problem				
Do you consider yourself to have a disability?	Yes		No	

Details of Impairment - **(Please tick all that apply to you)**	Physical Impairment		Learning Difficulty	
	Mental Health Condition			
	Other (please state)			