Dovercourt Surgery

NEW PATIENT QUESTIONNAIRE OVER 12 YEARS OLD

PLEASE BE AWARE THAT YOU WILL NEED TO PROVIDE YOUR NHS NUMBER ON THE PURPLE FORM, PHOTO ID AND PROOF OF ADDRESS WHEN REGISTERING.
EVERYONE THAT REGISTERS MUST BE PRESENT TO HAND IN THEIR OWN FORMS.
IT TAKES US 48 HOURS TO PUT YOU ON OUR SYSTEM

TITLE (PLEASE TICK) ☐ MR ☐ MRS ☐ MISS ☐ MS ☐ OTHER

SURNAME .....

FORENAME .....

GENDER (PLEASE TICK) ☐ MALE ☐ FEMALE

DATE OF BIRTH ..... **PLACE OF BIRTH** .....

ADDRESS .....

POSTCODE ..... **CONTACT TELEPHONE NUMBER** .....

Email_____

ETHINCITY (PLEASE TICK)

☐ WHITE BRITISH	☐ BLACK AFRICAN, NON-MIXED ORIGIN
☐ WHITE IRISH	☐ INDIAN
☐ WHITE, OTHER	☐ PAKISTANI
☐ BLACK CARIBBEAN	☐ BANGLADESHI
☐ BLACK CARIBBEAN AND WHITE	☐ CHINESE
☐ BLACK AFRICAN	☐ GYPSY/ROMANY
☐ ROMA SLOVAK	☐ ETHNIC GROUP, OTHER
☐ MIXED ORIGIN, OTHER	☐ ETHNIC GROUP NOT GIVEN/REFUSED

MAIN SPOKEN LANGUAGE .....

DO YOU NEED AN INTERPRETER? (PLEASE CIRCLE)

YES NO

DO YOU HAVE ANY INFORMATION OR COMMUNICATION NEEDS THAT WE NEED TO BE AWARE OF? (PLEASE CIRCLE)

YES NO

Please provide details of your needs:

DO YOU HAVE ANY SOCIAL CIRCUMSTANCES THAT WE NEED TO BE AWARE OF? (PLEASE CIRCLE)

YES NO

Please provide details of your circumstances: .....

.....

.....

PLEASE LIST ANY REGULAR MEDICATION YOU CURRENTLY TAKE:

.....

.....

ARE YOU ALLERGIC TO ANY MEDICATION? (PLEASE CIRCLE)

YES NO

If yes, what are you allergic to? .....

If yes, what kind of reaction did you have? .....

If yes, when did this occur? .....

HAVE YOU BEEN IN HOSPITAL WITHIN THE LAST 12 MONTHS? (PLEASE CIRCLE)

YES NO

Please state the Hospital you attended and the reason why below:

.....

.....

DO YOU SUFFER FROM OR HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS? PLEASE ALSO STATE THE DATE YOU WERE DIAGNOSED (PLEASE CIRCLE)

DEPRESSION	YES	NO	Date .....
ASTHMA	YES	NO	Date .....
DIABETES	YES	NO	Date .....
BLOOD PRESSURE	YES	NO	Date .....
HEART PROBLEMS	YES	NO	Date .....
STROKE	YES	NO	Date .....

LIST ANY OTHER ILLNESSES THAT YOU SUFFER FROM OR HAVE HAD

.....

.....

DO YOU HAVE ANY FAMILY HISTORY OF DISEASE SUCH AS HEART DISEASE, ARTHRITIS ETC.?

.....

.....

WHEN DID YOU LAST HAVE A TETANUS INJECTION?

WOULD YOU LIKE A HEALTH CHECK WITH A PRACTICE NURSE? (PLEASE CIRCLE)

YES NO

NEXT OF KIN

PLEASE PROVIDE US WITH YOUR NEXT OF KIN DETAILS

TITLE (PLEASE TICK) ☐ MR ☐ MRS ☐ MISS ☐ MS ☐ OTHER

SURNAME .....

FORENAME .....

GENDER (PLEASE TICK) ☐ MALE ☐ FEMALE

ADDRESS .....

POSTCODE ..... **CONTACT TELEPHONE NUMBER** .....

HOW IS THIS PERSON RELATED TO YOU? .....

CARER INFORMATION

WE ARE INTERESTED IN IDENTIFYING CARERS; ESPECIALLY THOSE PEOPLE WHO MAY BE CARING WITHOUT HELP OR SUPPORT

DOES SOMEONE LOOK AFTER YOU? (PLEASE CIRCLE)

YES NO

CARER'S DETAILS

NAME .....

ADDRESS .....

POSTCODE ..... CONTACT TELEPHONE NUMBER .....

DO YOU LOOK AFTER SOMEONE WHO IS ILL, FRAIL OR DISABLED? (PLEASE CIRCLE)

YES NO

DO YOU/THEY WANT ANY SHEFFIELD CARERS CENTRE INFORMATION? (PLEASE CIRCLE)

YES NO

ARMED FORCES

ARE YOU CURRENTLY SERVING/HAVE YOU SERVED IN THE ARMED FORCES? (PLEASE CIRCLE)

YES NO

SMOKING SURVEY

DO YOU SMOKE? (PLEASE CIRCLE)

YES NO

IF YES, WHAT DO YOU SMOKE? (PLEASE CIRCLE)

CIGARETTES CIGARS PIPE

HOW MANY DO YOU SMOKE? .....

IF YES, WOULD YOU LIKE ANY HELP OR ADVICE TO STOP SMOKING? (PLEASE CIRCLE)

YES NO

WHAT TYPE OF HELP WOULD YOU LIKE TO RECEIVE? (PLEASE CIRCLE)

DETAILED BOOKLET ONE-TO-ONE APPOINTMENT WITH A NURSE STOP SMOKING GROUP

IF NO, HAVE YOU EVER SMOKED? (PLEASE CIRCLE)

YES NO

IF YES, WHAT DID YOU SMOKE? (PLEASE CIRCLE)

CIGARETTES CIGARS PIPE

HOW MANY DID YOU SMOKE? .....

WHEN DID YOU GIVE UP SMOKING? .....

WOMEN ONLY

PLEASE STATE THE DATE OF YOUR LAST SMEAR? .....

DO YOU TAKE THE CONTRACEPTIVE PILL OR DEPOT INJECTION? (PLEASE CIRCLE)

YES NO

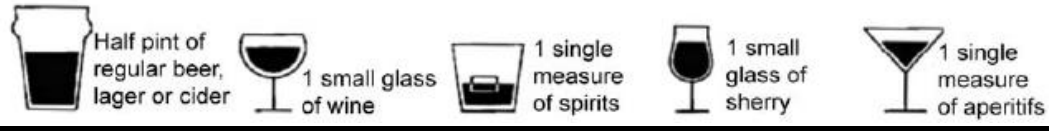
ONLINE SERVICES FOR OVER 18'S ONLY

WOULD YOU LIKE ACCESS TO ONLINE SERVICES AT THE PRACTICE ONCE YOU HAVE REGISTERED, TO ORDER PRESCRIPTIONS AND BOOK APPOINTMENTS WITH A DOCTOR? (PLEASE CIRCLE)

YES NO

ALCOHOL SURVEY

This is 1 unit of alcohol:



...and each of these is more than 1 unit:

PART 1

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 this last year?	Never	Less than monthly	Monthly	Weekly	Daily/ almost daily	

Scoring:

5+ Increasing/higher risk drinking

PART 1 TOTAL SCORE

IF YOUR SCORE IS 5 OR MORE, PLEASE COMPLETE PART 2

PART 2

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/ 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/ 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/ 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/ 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/ 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

PART 1 + PART 2 TOTAL SCORE

NHS Sheffield

A PATIENT'S GUIDE TO YOUR ELECTRONIC PATIENT RECORD AND THE SHARING OF INFORMATION

Please read the following information carefully. It will give you information about the sharing of your electronic patient record and the choices you need to make.

Today, electronic records are kept in all the places where you receive healthcare. These NHS Care Services can usually only share information from your records by letter email, fax or phone. At times, this can slow down your treatment and mean information is hard to access.

Your GP Practice uses a computer system called SystmOne that allows the sharing of full electronic records across different NHS Care Services. We are telling you about this as a patient you have a choice to make about how your Practice shares information about your care from your electronic patient record.

This form is not about your Summary Care Record, it is asking your sharing preferences regarding your full electronic GP record. You can choose to share or not share your electronic GP record with other NHS Care Services.

HOW IS MY DECISION RECORDED?
Your GPs computer system has two settings to allow you to control how your medical information is shared:

Sharing Out: this controls whether your full GP electronic patient record can be shared with other NHS Care Services where you are treated. Please record your preference:

Please tick: ☐ Yes (share) ☐ No (not shared)

Sharing In: this controls whether you agree for this Practice to view information you have agreed to share at other NHS Care Services. Please record your preference:

Please tick: ☐ Yes (share) ☐ No (not viewable)

PATIENT NAME (PRINTED) .....

PATIENT DATE OF BIRTH .....

PATIENT SIGNATURE ..... **DATE** .....