SKERNE MEDICAL GROUP - NEW PATIENT QUESTIONNAIRE
Adult

Thank you for choosing to register with Skerne Medical Practice

During your registration, we are required to record detailed information regarding your medical history. The majority of information will be covered by the Medical Professional in your new patient consultation.

It would be very helpful if you could complete the following questions.

Personal Details

Surname (Last name)	Forenames	Title	DOB

Address: ……

Post code: …………………………………………………..

Home Telephone Number……..……………………. Mobile Telephone Number: ……………………………………
Please indicate preferred contact number

Occupation: …………………………………………………………………..

E-Mail address: …………………………………………………………….

We will automatically register you for our text appointment reminder service. Please advise reception if you do not require this service.

- Do you look after someone? Yes / No Name:…………………………………………………………………
- Does someone look after you? Yes / No Name:……………………………………………………………….

Next of Kin

Surname ………………………………… **Forename** ……………………………………… **DOB** …………………………………..

Their relationship to you is: ……………………………………………

Their address is: ……

Post code:…………………………………………………..

Their contact numbers are: Home…………………………………….… Mobile …………………………………………………

Medication

If you are on repeat medication we will nominate the local pharmacy to process your usual medication unless you indicate an alternative.

I currently take the following prescribed medication:

a.	b.
c.	d.
e.	f.
g.	h.

Family History

Have any of your first degree relatives, (mother, father, brothers or sisters) ever had a significant health problem such as heart disease, stroke or cancer?

Relative	Health Problem	Relative's age at onset

Females Only:

What form of contraception do you currently use/have?:

Implant Coil Patch Injection Oral Contraceptive Pill please state ……………………………

other…………………………

Allergies

I have a known allergy to the following drug/s (e.g. penicillin)……………………………………………………

……..

Alcohol Consumption

Please complete the attached questionnaire and circle one answer that closely matches your alcohol consumption. You may be offered advice or further intervention about drinking habits if you wish to receive them.

Smoking

Do you currently smoke? YES/NO

If yes, how many cigarettes per day do you smoke? ……………………………………………………………..

Would you be interested in help to quit smoking? YES/NO

Ethnic Background

Please tick the appropriate box to assist us in determining your risk of heart disease.

British	□ .9i0	Other white background	□ .9i2
Polish	□ .9i2F	Indian	□ .9i7
Pakistani	□ .9i8	Chinese	□ .9iE
Caribbean	□ .9iB	Ethnic category not stated	□ .9iG

Other (Please specify)____

Language

My first spoken language is:……………………………………………………………………………………….

Disability

Are you registered disabled? YES/NO

If yes, what is your disability? ………………………………………………………………………………….

Summary Care Record

The Summary Care Record is a posting on an NHS Website that records your significant medical problems, medication and allergies and is available to authorised Health Care Professionals in England. This can assist in your medical treatment away from the practice.

Do you agree to having a Summary Care Record (SCR)? Yes/No

Appointment Cancellations

The practice aim to offer you convenient appointments and therefore request that if you are unable to attend or no longer require an appointment you have made, it is cancelled in advance.
Please circle to confirm you agree to make every effort to cancel unwanted appointments?

I AGREE
Signature ……………………………………………………………….. Date ………………………

Patient Responsibilities when visiting our Practice

- Behave respectfully to staff and other patients or visitors
- Have consideration for our staff and other patients or visitors
- Behave in a way which keeps self and others safe within our practice
- Accept responsibility for your own behaviour and choices/actions

Unacceptable standards of Behaviour within our Practice

- Violence
- Excessive noise eg recurrent loud or intrusive conversation or shouting
- Threatening or abusive language involving swearing or offence remarks
- Derogatory racial or sexual remarks
- Malicious allegations relating to members of staff, other patients or visitors
- Offensive sexual gestures or behaviours
- Any use of alcohol or drugs on practice premises and/or Drug dealing on practice premises
- Wilful damage to practice property and/or Theft
- Threats or threatening behaviour – keep self and others safe

I have read and agree to follow patient responsibilities and standards of behaviour.
Signature: ………………………………………………………………………………… Date: ………………………………………..

Thank you for your time and cooperation. This information will be added to your electronic medical record by our staff.

Neil Bunney
Practice Manager
April 2018

STAFF ONLY:

Photo ID:

<u>Type</u>	<u>Ref Number</u>
Current Passport	……………………………
Photo Driving Licence	……………………………
Original Birth Certificate	……………………………

Address ID:

<u>Type</u>	<u>Ref Number</u>
Utility Bill Gas, Electricity, Water, Phone Landline)	……………………………
Local Authority Bill	……………………………
Bank Statement	……………………………
Benefit Proof	……………………………