# OLD SCHOOL SURGERY
# NEW PATIENT QUESTIONNAIRE

The information that we are seeking on this form is to help us offer you the best advice and treatment that we can. Please tell us as much as you can and return this form to the surgery together with your registration form and documents to verify your identity.

**ABOUT YOU**

| | | | |
|---|---|---|---|
| Title | | Date of Birth | |
| Surname | | Forename (s) | |
| Previous Name | | Occupation | |
| Address | | Home Phone | |
| | | Mobile Phone | |
| Post Code | | Email Address | |
| Previous Address: (must be completed) | | Previous GP: (must be completed) | |

| | | | | |
|---|---|---|---|---|
| Marital Status (Circle as appropriate) | Married or Civil Partnership | Widowed | Divorced or Separated | Single |
| Details of parent or guardian (if under 16) | | | | |

**WHY WE NEED TO VERIFY YOUR IDENTITY**

It is not uncommon for people to use false names to register with practices to obtain treatment and prescriptions. Unfortunately this costs the NHS money and we all need to play our part in attempting to combat this fraud.

It is now NHS policy that all individuals seeking to register with practices, either as a new patient or temporary residents, should provide proof of identity. This means verifying your name and also where you live or used to live.

Acceptable documents for proof on name are:

| | | |
|---|---|---|
| Passport | Marriage certificate | National Insurance Card |
| Driving Licence | Birth Certificate | Other form of Photographic Identification |

Acceptable documents for proof of address are:

| | |
|---|---|
| Utility bills (gas, electricity or telephone etc.) | Bank or Credit Card Statement |
| Home insurance Policy | Other – Official letter with current address. |

When returning your completed registration form and new patient questionnaire please present one document to verify your name and another to verify your address.

---

For Practice use only

| | |
|---|---|
| Identification Verified by (please sign) | |
| Date: | |

**ETHNIC GROUP (Circle the appropriate group)**

| | | | |
|---|---|---|---|
| White British | White Irish | Other White Background | |
| Mixed White and Black Caribbean | Mixed White and Black African | White and Asian | Other Mixed Background |
| Indian | Pakistani | Bangladeshi | Other Asian Background |
| Caribbean | African | Other Black Background | |
| Chinese | Other Ethnic Group: (Please specify) | | Declined to Say |

**YOUR HEIGHT AND WEIGHT**

| | | | |
|---|---|---|---|
| Height (indicate units used e.g. feet & inches or cms) | | Weight (indicate units used e.g. stones & pounds or kgs) | |

**YOUR MEDICAL HISTORY**

| | | | |
|---|---|---|---|
| Do you live with any of the following conditions? (please provide approximate date of diagnosis below) | | | |
| Diabetes Type 1 | Diabetes Type 2 | Hypertension (high blood pressure) | Epilepsy |
| Heart Disease | Mental Health | COPD/Emphysema | Asthma |
| Cancer | Deafness/hard of hearing | Blindness/partial sight | |
| Other (please specify) | | | |
| If so, when was your last check-up? | | | |
| Have you had any serious illnesses, accidents or operations? | | | |
| Please list all events with dates | | | |
| ****Important - Are you allergic to anything? YES/NO (e.g., penicillin, stings, eggs, nuts)** | | If yes, please provide details: | |
| When was your last | Blood Pressure | Tetanus Vaccination | Cervical Smear (women only) |
| | | | |

**IMMUNISATION HISTORY – Please provide a full copy of immunisations for children under 5 years of age**

| **Have you had any of the following immunisations? Give dates if known:** | | | |
|---|---|---|---|
| Diphtheria/Tetanus/Whooping Cough/Polio & Hib | | Meningitis C | |
| Hib/MenC Booster | | Pre-school Booster | |
| Mumps/Measles/Rubella (MMR) | | School Leavers Booster | |
| HPV | | Pneumococcal | |
| Other Immunisation (please specify) | | | |

**FAMILY HISTORY**

| Have your parents, brothers or sisters had any of the following conditions before the age of 60? | | | |
|---|---|---|---|
| Diabetes | | Asthma | |
| High Blood Pressure | | Epilepsy | |
| Heart Attack | | Other conditions: (please specify) | |
| Stroke | | | |

**CURRENT MEDICATION**

| Please supply details of your current medication – Please note the practice may access your central records to confirm medications listed below. | |
|---|---|
| **Name of medication** | **Dosage** |
| (please attach a copy of your current prescription provided by your previous practice) | |

**FEMALE PATIENTS ONLY**

| | |
|---|---|
| Have you ever had a smear test | Yes / No |
| If yes, when did you last have a smear test: | |

**If you have recently received a reminder letter from the cervical screening service, please book and appointment with the Practice Nurse**

**SMOKING**

| Do you Smoke? | Yes / No | Have you ever smoked | Yes / No |
|---|---|---|---|
| **If you are an Ex-Smoker:** | | | |
| When did you stop? (approx. month & year) | | | |
| **If you are a current smoker:** | | | |
| What do you smoke? | Cigarettes / cigars / pipe | How much do you currently smoke? (cigarettes/day or grams tobacco/week) | |

**ALCOHOL**

Drinking a sensible amount of alcohol is unlikely to do you any harm. However, for some people social drinking can lead to heavy drinking which can cause serious health problems.

If you do not drink alcohol, please tick the box below – do you not need to take any further action

☐ I do not drink any alcohol

If you do drink alcohol please complete the attached Alcohol Form and return it to the practice.

**Name:**_____ **Date of Birth:**_____

**Old School Surgery - Alcohol MOT**

**What health risk are you taking?**

| | The score relating to each question is indicated within the ( ) | Score |
|---|---|---|
| 1 | How often do you have a drink containing alcohol?<br><br>Never do (0) Less than monthly (1) 2-4 times a month (2) 2-3 times a week (3)<br>4 or more times a week (4) | |
| 2 | How many standard drinks (e.g. small glass of wine, pint of beer, single measure of spirits) containing alcohol do you have on a typical day when you are drinking?<br><br>1 or 2 (0) 3 or 4 (1) 5 or 6 (2) 7 or 9 (3) 10 or more (4) | |
| 3 | How often do you have six or more drinks on one occasion?<br><br>Never (0) Less than monthly (1) Monthly (2)<br>Weekly (3) Daily or almost daily (4) | |
| | **TOTAL for question 1,2 and 3 = If over 4 (Woman) or 5 (Man) please proceed to next questions** | |
| 4 | How often during the last year were you unable to stop drinking once you had started?<br><br>Never (0) Less than monthly (1) Monthly (2)<br>Weekly (3) Daily or almost daily (4) | |
| 5 | How often during the last year have you failed to do what was expected of you because of drinking?<br><br>Never (0) Less than monthly (1) Monthly (2)<br>Weekly (3) Daily or almost daily (4) | |
| 6 | How often during the last year have you needed a drink in the morning to get yourself going after a heavy drinking session?<br><br>Never (0) Less than monthly (1) Monthly (2)<br>Weekly (3) Daily or almost daily (4) | |
| 7 | How often during the last year have you had a feeling of guilt or remorse after drinking?<br><br>Never (0) Less than monthly (1) Monthly (2)<br>Weekly (3) Daily or almost daily (4) | |
| 8 | How often during the last year have you been unable to remember what happened the night before because you had been drinking?<br><br>Never (0) Less than monthly (1) Monthly (2)<br>Weekly (3) Daily or almost daily (4) | |
| 9 | Have you or someone else been injured as a result of your drinking?<br><br>No (0) Yes, but not in the last year (2) Yes, during the last year (4) | |
| 10 | Has a relative, friend, doctor or another health worker been concerned about your drinking or suggested you cut down?<br><br>No (0) Yes, but not in the last year (2) Yes, during the last year (4) | |
| | Total Score: | |

---

**Practice use only:**

1. **If score less than 4 (female) or 5 (male) record as - <u>Section A – 3 questions</u>**
2. **If score equal to 4(female) or 5(male) – Full audit required – record as <u>Section B – 10 Questions</u>**