New Patient Questionnaire

Stony Medical Centre

If you need any support completing these forms please ask our reception teams who will be happy to help you. Please ensure you complete the Purple GMS (General Medical services) form clearly at the front of this leaflet.
You can obtain your NHS number from your previous GP surgery.
We do understand that not all questions on our registration forms are applicable to all patients. However it is important we use the registration process to capture as much information as possible. This is to ensure that we are offering you the best standard of care and can signpost patients who may need extra support at the point of registration. Please complete the registration forms to the best of your knowledge with as much information as possible.

PATIENT NAME:……………………………………..	**DOB:** ……………………………………..

We recommend that patients provide identification when registering at the practice. If you're unable to provide identification we can still register you. However you won't be able to access our online services without proof of identification.
We do recommend patients sign up for online services.

Have you been registered with our GP Practice before? Yes ☐ No ☐

If you have previously been de-registered under our zero-tolerance scheme you must not register with our practice, without first writing to the Practice Manager with your request. If the practice declines your request to register they will inform you in writing of the decision. The practice has a right to remove your registration at their discretion at any time if you have previously been removed from our list for abusive behavior and not informed them at the point of re-registering.

ONLINE PATIENT SERVICES:
I wish to have access to the following online services (please tick all that apply):

1. Booking appointments ☐
2. Requesting repeat prescriptions ☐
3. Accessing my medical record ☐

Please provide photographic identification and proof of address to register with our online services.

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CONTACT DETAILS: Mobile No:………………………………………	Work No:……………………………………………
Telephone No:…………………………………	Email address:………………………………..
Consent for SMS messages Do you consent to us contacting you by SMS messages Yes ☐ No ☐	Consent for email correspondence Do you consent to us contacting you by email correspondence Yes ☐ No ☐

NEXT OF KIN:
Name:……………………………………………………………………………………………

Address (including postcode):…………………………………………………………………

Contact number:………………………………………………………………………………..

Your relationship:………………………………………………………………………………

CARE PLAN:
Would you like to be provided with an ACP booklet (Advanced Care Planning) Yes ☐ No ☐

Advance care planning is a process that enables individuals to make plans about their future health care.

PHARMACY CHOICE:
Name and address of Nominated Pharmacy for prescriptions:………………………………………………………………………………………

SUMMARY CARE RECORD:
Your records will automatically be coded for an Enhanced summary Care record. If you do not want a summary care record, please ask at reception for an OPT out form and tick here ☐
Your Summary Care Record is a short summary of your GP medical records. It tells other health and care staff that care for you about the medicines you take and your allergies. It means they can give you better care if you need health care away from your usual doctor's surgery: for example, in an emergency, when you're on holiday, when your surgery is closed, at out-patient clinics or when you visit a pharmacy.

THIRD PARTY ACCESS:
In the Practice we aim to provide you with the highest quality of healthcare. To do this we must keep records about you, your health and the care we have provided or plan to provide to you. Everyone working for the NHS has a legal duty to keep information about you confidential.
If you would like a family member or carer to have access to your medical records on your behalf we need to keep their contact details on your records.
The person you nominate must be happy to have their details recorded in your medical records. If you wish to nominate someone for this reason please provide us with their details and sign below that you consent to this
Name of nominated individual ……………………………………………………………………

Your signature …………………………………… Date ……………………………………….....

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MAIN SPOKEN LANGUAGE:

English (please tick) ☐	Other (please state): ……………………………………..…… Do you require an interpreter: Yes☐ No ☐

ETHNITCITY:

British ☐	Irish ☐	Other White ☐	Mixed ☐	Indian ☐	Pakistani ☐
Bangladeshi ☐	Other Asian☐	Caribbean ☐	African ☐	Other Black ☐	Chinese ☐

LIFESTYLE:

Blood pressure reading (please use pod in reception if available)	

HEIGHT/ WEIGHT:

Height (In meters):	Weight (In kg):

SMOKING STATUS:

Never smoked tobacco ☐	Ex- smoker ☐	Smoker ☐

IF YOU ARE A SMOKER PLEASE ANSWER/TICK THE FOLLOWING:

Daily cigarette consumption:	
Pipe smoker ☐	User of electric cigarette ☐
Rolls own cigarettes ☐	Drug smoker ☐
Would like help to stop smoking ☐	Not interested in stopping smoking ☐

PERSONAL MEDICAL HISTORY (Please tick relevant boxes and date of diagnosis):

Angina ☐	Arthritis ☐	Asthma ☐
Diabetes ☐	Epilepsy☐	Hypertension ☐
Learning Disability ☐	Osteoporosis ☐	Mental Health ☐
Skin Disorders ☐	Thyroid Disorder ☐	History of COPD ☐
Cancer ☐	Other (please state) ………………………………………………..	

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FAMILY HISTORY:

Heart problems ☐ Relationship & age …………………………………………………………………..….
Stroke (CVA) ☐ Relationship & age ………………………………………………………………………..
Cancer ☐ Relationship & age ………………………………………………………………………………..
Diabetes ☐ Relationship & age …………………………………………………………………………….
Asthma ☐ Relationship & age ……………………………………………………………………………….

REPEAT MEDICATION:
If you are taking regular medication from your previous GP you will need to book an appointment before GP's can issue this, please allow yourself plenty of time so you do not run out of medication and bring along previous prescription requests/ medication with you to your appointment.

Please note we do not accept prescription requests over the phone unless you are housebound. Prescriptions take 48-72 hours to be processed.

SENSITIVITIES/ ALLERGIES:

Please advise us of any sensitivities or allergies
……
……

NEW PATIENT APPOINTMENT:

Would you like to be booked an appointment for a new patient health check with our Health Care Assistant? You can choose at the appointment to have a quick and simple test for HIV.

New patient appointment ☐ HIV screening accepted ☐ HIV screening declined ☐

VETERANS:

Are you or have you served in the armed forces?

Member of armed forces ☐ Served in the armed forces ☐

What is your service number?...

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CARERS:

Are you a carer for someone? Yes ☐ No ☐
Is there someone that you rely on for your care? Yes ☐ No ☐
Do you have carer support? Yes ☐ No ☐ If you have ticked yes would you like to be referred to carers MK? Yes ☐ No ☐

WOMEN ONLY:

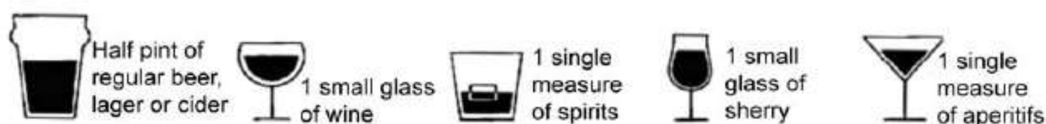
Have you had a hysterectomy? Yes ☐ No ☐ Do you still require a smear? Yes ☐ No ☐

LOOKED AFTER CHILDREN:

Are you a looked after child? (Aged 13-21 years) Yes ☐ No ☐

DO YOU DRINK ALCOHOL – Please see the below alcohol chart before completing your answers on the following page:

This is one unit of alcohol…



…and each of these is more than one unit

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Please complete below by circling your answers:

FAST	**Scoring system**					**Your score**
	0	**1**	**2**	**3**	**4**	
MEN: How often do you have EIGHT or more drinks on one occasion? WOMEN: How often do you have SIX or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only answer the following questions if the answer above is Never (0), Less than monthly (1) or Monthly (2). STOP here if the answer is Weekly (3) or Daily (4).						
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	
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	
In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	

COMMUNICATION:
We want to make sure you can read and understand the information we send you. If you find it hard to read letters or if you need someone to support you at appointments, please let us know in the answers given below.

Hearing impairment- please answer below if you have a hearing impairment	Visual impairment- please answer below if you have a visual impairment
Do you lip read ☐ Do you wear a hearing aid ☐ Areas of difficulty with hearing, other……………. ………………………………………………………. Is an interpreter needed, i.e. British Sign Language ☐	Do you need information in a different format ☐ If so please tick below what format you need it in: 20 point sans serif font ☐ 24 point sans serif font ☐ 28 point sans serif font ☐ Requires information in electronic downloadable format ☐

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LIVING STATUS:

Are you living in a care home?	Yes ☐	No ☐
Are you homeless?	Yes ☐	No ☐

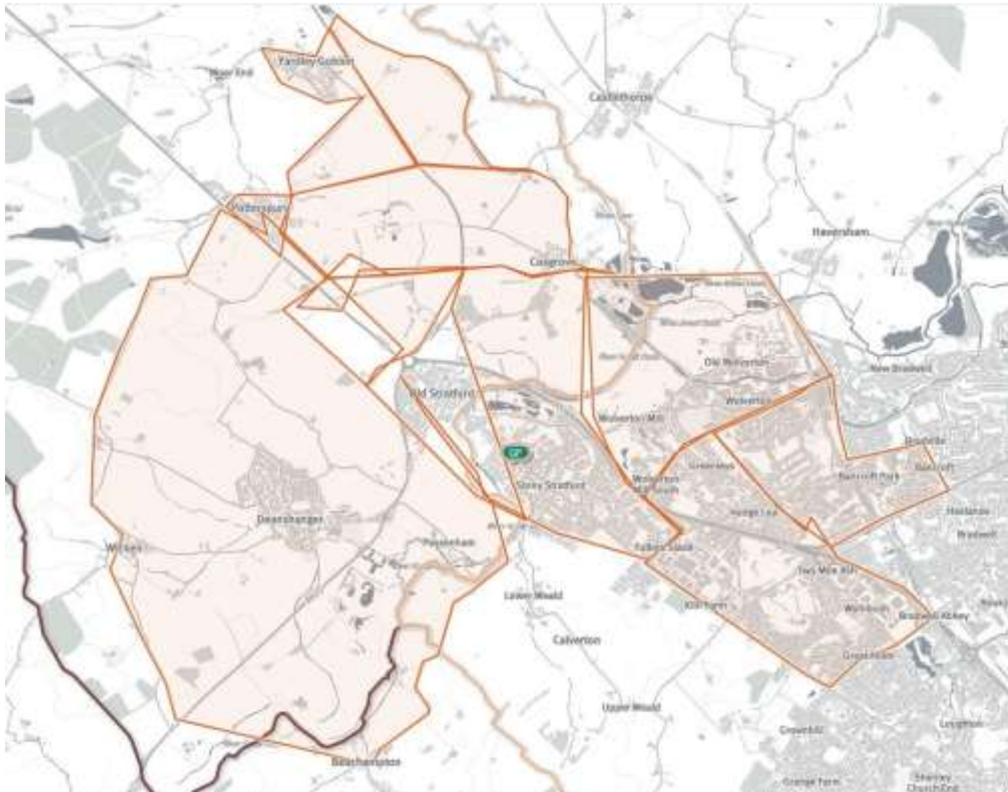
If you are homeless or at risk of homelessness please complete the information below. The reason we ask for this information is so that we can send a referral to the local homelessness team. Please only fill in below if you CONSENT to a referral to the local homelessness team.

What is your national insurance number ………………………………………………………………
Date you became homeless or likely to become homeless…………………………………………….
What is your household/ living situation? Single ☐ Couple ☐ Family with dependents ☐ Family with non-dependents ☐
What is your current accommodation? Owner ☐ Private rented ☐ Council tenant ☐ House Association tenant ☐ Living with parents ☐ Staying with friends ☐ Sleeping rough ☐ Hostel ☐ Night shelter ☐ Other ☐

Please be aware once the referral has been sent, the practice will be unable to provide you with further information regarding the referral .The homelessness team will contact you directly.

You can only register at our practice if you live within the catchment area for our practice. Please only submit your registration if you live within the areas below – IF you have completed this form and do not live in our boundary area you can take this form to any surgery in Milton Keynes close to your home address

Practice Boundary area map



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CONSENT
I consent to the practice contacting me by text message and/or email message for the purposes of health promotion and for appointment reminders.

I acknowledge that appointment reminders by text and/or email are an additional service and that these may not take place on all/or on any occasion and that the responsibility of attending appointments or cancelling them still rests with me. I can cancel the text and/or email message facility at any time.

Text messages are generated using a secure facility however I understand that they are sent over a public network onto a personal telephone and as such may not be secure, however the practice will not transmit any information which would enable an individual patient to be indentified.

I agree to advise the practice if my email address changes and also if my mobile telephone number changes or if this is no longer in my possession.

The practice does not share mobile phone contact details or email addresses with any external non-NHS organisation.

Your medical records may be used for financial or clinical audit, post payment verification checks, medical research or education purposes.

Signature	Date

I confirm that the information given above is accurate to the best of my knowledge and that I live within the practice boundary catchment area as detailed in this pack and I confirm that I have read and understood the **Contract of care** provided in this pack.

Signature	Date

CONTRACT OF CARE
The GPs, Nurses, Practitioners and Staff aim to provide the highest possible care to our patients. The aim of this Contract of Care is to ensure that you understand the practice policies, why such policies are in place and then follow them. We particularly recommend that you read closely the details relating to our Appointment, Repeat Prescribing and Behaviour expectations.

Your responsibilities:	**Practice responsibilities:**
Comply with recommended treatment	Offer access to quality medical services
Participate in appropriate screening and prevention programmes	Provide you with an appointment with a GP or appropriate healthcare professional or signpost you to a suitable alternative service in line with our appointments procedure
Commit to a healthy lifestyle with support from the Practice if required	Enable you to relevant appointments with the right clinician the first time
Treat clinicians and staff with dignity and respect at all times	Treat you with dignity and respect at all times.
Be aware of our practice booking system and use this appropriately and book with the appropriate clinician	Ensure all patients have access to a patient information leaflet which includes information of how to book an appointment

Information about all the services we provide are detailed on our website If you do not have access to the internet please ask at reception for a practice leaflet. Before deciding that you wish to join the Practice we ask that you review this information in order to decide whether you can follow the policies presented by the Practice in line with the General Medical Services GP contract.