Cumbria Health on Call

Glenridding Health Centre

NEW PATIENT QUESTIONNAIRE ADULT

Please complete as many questions as you can. The information will help the practice to provide better medical care for you. This information will be held in the strictest confidence as per Data Protection.

Surname: …… First Name: …… Maiden name: ……..

Date of Birth: ……..

Current Address: ……

……

……

……

Postcode: ……

Tel. No: …….. Mobile No: ……

Email Address: ……

1. Contact Permission

We like to keep or patient informed on events in practice and any changes/additional services that we introduce. We keep our patient informed via our practice Newsletter and Patient Participation Group and would like to include you in our email circulation. We treat personal details as confidential and follow all data protection process. We will only use patient contact details for medical reasons or practice updates where permission has been given.

Yes please contact me with practice updates ☐ No thank you, I do not want you to send me updates ☐

Do you consent to being contacted via: Telephone ☐ Mobile ☐ Email ☐

Marital Status:Single/Married/Separated/Divorced/Widowed

Occupation: ……

Height: ……m/ft Weight: ……kg/st

Ethnic Origin: …… First Language: …… Interpreter required? Yes/No

Refugee – If Yes, from which country? ……

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Which of the following options best describes how you think of yourself?
Woman (including Tran's woman) ☐ Man (including Tran's man) ☐ Non-binary ☐

In another way (pleases state): ……

Is your gender identity the same as the one you were given at birth?

Yes ☐ No ☐

Which of the following options best describes how you think of yourself?

Lesbian ☐ Bisexual ☐ Gay ☐ Heterosexual/Straight ☐ In another way (pleases state):

……

2. Previous Doctor

Name: ……..

Address: ……

……

…… Postcode: ……

3. Next of Kin

Name: …….. Contact No: ……

Relationship: ……

4. Personal Medical History

Please list serious or chronic illnesses, operations, or disabilities:		
Year:	**Have you ever needed treatment for:**	
	Epilepsy / fits	Yes No
	Blindness / Glaucoma	Yes No
	Blood Pressure (hypertension)	Yes No
	Diabetes	Yes No
	Stroke or TIA	Yes No
	Heart Attacks	Yes No
	Asthma	Yes No
	Cancer	Yes No
	Depression	Yes No
	Mental Health Problem	Yes No
	Kidney Disease	Yes No

Please turn over

	Dementia	Yes No
	COPD (Bronchitis or Emphysema)	Yes No
	Thyroid Problem	Yes No
	History of Fractures	Yes No
	Osteoporosis	Yes No
	Rheumatoid Arthritis	Yes No
	Any history of Operation or procedure? If Yes please state what?	Yes No

5. Medical History Of Family – (brothers, sisters, parents, uncles, aunts, grandparents)

Has any close relative suffered from the following:		**(Please note if it was before the age of 60):**
Blood Pressure (hypertension)	Y N	
Heart Attack or Angina	Y N	
Diabetes	Y N	
Stroke or TIA	Y N	
Cancer	Y N	

6. Social History

1. Do you live alone? Yes/No
2. Are you homeless? Yes/No
3. Do you have a carer? Yes/No

Name of Carer: …… Relationship: …… Tel. No: ……

Do you consent to us contacting your carer? Yes/No
4. Are you a carer for a relative or friend? Yes/No
5. Are you a care leaver? Yes/No
6. Have you ever or are you currently serving in the Armed Forces? Yes/No
7. Do you have a Social Worker? Yes/No

8. Have you suffered or are you currently suffering domestic abuse? Yes/No
(including coercive control, financial, verbal, physical, sexual or emotional abuse)
If yes, do you require any support around this?

What is their name/contact details ……

7. Disability, Age Related Problems or Special Needs

Do you have any problems with:	
Vision	Y N
Speech	Y N
Mobility	Y N
Hearing	Y N
Learning Difficulties	Y N
Autism	Y N

Please turn over

Cumbria Health on Call

8. Reasonable Adjustments

What help do you need to see the nurse or doctor – e.g. longer appointments/appointment at a quieter time?

……

9. Lifestyle

Please circle which diet you follow: Vegetarian/Vegan/Weight Reducing/Low Fat/Low Salt/High Fibre/

Dairy Free/Diabetic/Gluten Free /Normal/Other

Do you smoke? Yes/No

Cigarettes: …… per day Cigars:…… per day

Have you ever smoked? Yes/No If yes, when did you stop? ……..

If you do smoke, do you wish to discuss stopping smoking? Yes/No

Do you drink alcohol? Yes/No How much? …….. units per week

Questions	0	1	2	3	4	Your Score
How often do you have a drink that contains alcohol	Never	Monthly of less	2-4 times per month	2-3 times per week	4+times per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking	1 - 2	3 - 4	5 -6	7 -9	10+	
How often do you have 6 or more standard drinks on one occasion	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Do you feel you need support with your drug/alcohol intake? Yes/No

10. Exercise

Do you undertake any regular sport or exercise? Yes/No

Daily/2-3 Times a Week/Weekly/Occasionally

What exercise do you do? ……

Please turn over

11. Blood Pressure

Have you ever had your **BLOOD PRESSURE** tested? Yes/No

If so, when? ……..

Has it even been **HIGH**? Yes/No

12. Drugs & Medicines

Are you taking any drugs, medicines, tablets or contraceptive pills? Yes/No

If so, which one(s)? Name of Medicine/Dosage:

You will need a GP appointment before any drugs can be dispensed

……

……

……

Please provide a printout of your medication if you need it on a regular basis

Are you able to manage your medication yourself? Yes/No

If No – what help do you need? ……

13. Allergies

Please list any medicines, foods, plants or animals to which you think you are allergic:

……

14. Vaccinations (if known)

When was your last?

Diptheria/Tetanus/Polio: ……..

Influenza: ……..

Pneumonia: ……..

Any Travel Immunisations? ……

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Cumbria Health on Call

15. Only answer the questions relevant to you

Have you/do you attend a family planning clinic? Yes/No
Do you take a contraceptive pill/injection? Yes/No
Which one? …….
How long have you been taking the pill/injection? …….
Are you fitted with a coil? Yes/No
When was it fitted? ……..
Have you ever had a cervical smear? Yes/No
If Yes, date of last one: ……
Result of cervical smear: ……..
Have you ever been pregnant? Yes/No
If yes: a) How many children do you have? …….
b) Have you had any miscarriages? Yes/No
Have you been immunised against Rubella? Yes/No

Online Access

Our surgery offers Patient Online Access, this allows patients to:

- View a summary of their Medical Records
- Book appointments
- View / Request Repeat Medication
- View test results

At registration the practice will automatically allocate patient online access for all new patients; where an email address has been provided and relevant photographic identification has been verified.

Patient still need to confirm registration for these services, via the Patient online Access website.

If you are unsure on how to confirm registration please ask the Receptionist who can advise you!

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For Internal Use Only:

Practice administration checklist-

Identification check

Patients are requested to present 2 forms of I.D. (one being a photograph)
Please tick I.D. checked:

Utility bill / Driving License / Passport / Bus pass / Student I.D. / Other (Please specify)

DO NOT register until all information is completed

Date: ……Please allow 7 days for registration to be completed

For Reception Use Only	
• **Form checked and fully completed**	**Yes / No**
• **GMS1 form received and checked**	**Yes / No**
• **Practice Leaflet given**	**Yes / No**
• **ID checked**	**Yes / No – Detail…….**
• **Does patient want online access**	**Yes / No / Proxy**
• **Named GP**	**Dr Lucy Dickinson**
• **Verbal Invite for Over 40 Health Check**	**Yes / No / Not applicable** **Nurse …….. Date……..**
• **On Medicines book appt with Doctor to add medicines** • **Dispensing patient - YES / NO**	**Doctor…….. Date ……..** **Receptionist Name: ……** **Date……** **Pass/Put in Admin tray YES / NO**

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For Admin Use Only	
• GP2GP notes downloaded	Yes / No
• Registration completed	Yes / No
• New patient template(Reception Admin) (Ardens V17.1) completed	Yes / No If Yes, Code all relevant information in template, alcohol, smoking information, NOK, lifestyle, family history, Carer, Disabilities etc. Send out advice via text or post if relevant.
• Dispensary status and location if EPS	Yes / No
• Checked for safeguarding vulnerability	Yes / No If yes, send to practice safeguarding team to code, add alerts and send to GP SG lead to review records.
• Is patient on repeat medications or have allergies	Yes / No
• Is an interpreter required?	Yes / No If yes, code and document major alert Yes / No- If yes, ensure major alert to medical record is added with patient's language. Consider if longer appointments will be required
• Has the patient ever served in the military?	Yes / No If yes, code as military veteran
	Admin Name……
	Date……

Please turn over