New Patient Registration and Medical Questionnaire

Adult

Version 1.3
July 2022

This questionnaire is to help us gather information whilst we are waiting for your full medical record to be received from your previous Doctor**. PLEASE ENSURE ALL SECTIONS ARE COMPLETE** This will help the transfer run as smoothly as possible.

Please complete in **BLOCK CAPITALS** and tick relevant boxes.

- Please complete a separate form for each adult registering
- When handing in this form, it would be helpful if you could bring photo ID & proof of address
- In order to provide care and ensure safety we may need to share information with other healthcare professionals. If you have any concerns regarding this, please speak to the Practice Manager.

Registration Details

All questions marked (*) are required by the surgery to complete the registration (please complete one registration form for each person)

Title*	
Pronouns	
Surname*	
Previous Surname*	
Forenames*	
Date of birth*	
Town of birth*	
Country of birth*	
NHS No.	
Home address*	
Home telephone number*	
Mobile telephone number*	
Email Address*	

Ethnicity

What is your ethnic group? Please tick one box that best describes your ethnic group or background from the options below:

White: British ☐ Irish☐ Irish Traveller☐ Traveller Gypsy/Romany☐ Polish☐ Any other white background (please note here):
Mixed: White and Black Caribbean☐ White and Black African☐ White and Asian☐ Any other Mixed background (please note here):
Asian or Asian British: Indian Pakistani☐ Bangladeshi☐ Any other Asian background (please note here):

Continued Pg 2

Black or Black British: Caribbean☐ African☐ Somali☐ Nigerian☐ Any other Black background (please note here):
Another ethnic group: Chinese Filipino☐ Any other ethnic group (please note here):
Not stated: Not Stated should be used where the PERSON has been given the opportunity to state their ETHNIC CATEGORY but chose not to.☐

Gender

What is your current gender identity (Please tick one) *?

	Male
	Female
	Transgender Male/Trans Man/Female-to-Male (FTM)
	Transgender Female/Trans Woman/Male-to-Female (MTF)
	Genderqueer, neither exclusively male nor female
	Additional Gender Category/ (or Other), please specify: _____
	Choose not to disclose
What Sex were you assigned at Birth on your original Certificate (Please tick one) *	
	Male
	Female
	Choose not to disclose

Next of Kin and Emergency Contact Details

Name*	
Contact number*	
Relationship to Patient	

To help us trace your previous medical records please provide the following information

Previous address in the UK*			
Name of Previous GP Practice*			
Is this your first NHS registration in England? *		Y/N If yes, what date did you enter the UK?	
Please indicate if you have served in the UK Armed Forces and/or been registered with a Ministry of Defence GP in the UK or overseas along with joining/leaving date:			
Regular		Reservist	
Veteran		Family Member (Spouse, Civil Partner, Service Child)	

Communication and Accessibility Needs

Do you have any communication requirements?				
Sign Language			Large Print	
Interpreter	(Language required)			
Other (please specify)				

Medical Questionnaire

Please take the time to complete this document as this information helps us to know more about you, as your record will not reach us immediately. As part of the registration process, you may receive a phone call from one of our Health Coach Team for a brief discussion. This is so we can find out a little more about how we can provide appropriate care for your needs.

Measurements

Height	
Weight	
Waist	
Blood Pressure Reading	

Personal Medical History (if you require more space, please use a separate sheet)

Have **you ever** suffered with any of the following (please tick all that apply)				
	Year Diagnosed			Year Diagnosed
Blindness/Glaucoma			Epilepsy	
High Blood Pressure			Heart Attack	
Diabetes			Stroke/CVA	
Asthma/COPD			Cancer (where)	
Other (please specify)				

Family Medical History (if you require more space, please use a separate sheet)

Has any **close relative** ever suffered with any of the following (please tick all that apply)						
		Year Diagnosed				Year Diagnosed
Blindness/Glaucoma				Epilepsy		
High Blood Pressure				Heart Attack		
Diabetes				Stroke		
Asthma/COPD				Cancer		
Other (please specify)						

Medication

If you take any repeat medications, please provide a copy of your repeat medication slip or complete the table below (if you require more space, please use a separate sheet).

Name of Medication	Strength	Dosage

Care at Home

Please tick all that apply to you				
Are you a carer? If yes, who do you care for?	Y/N		Do you have a carer? If yes, who is your carer?	Y/N
Are you housebound?			Are you registered disabled?	
Do you have a keypad number?			Do you have a Lasting Power of Attorney for health in place?	
Please provide relevant details about items you have ticked above				
Do you feel lonely or isolated?	Yes	No		
If yes, would you like support with this?			**OFFICE USE ONLY:** If yes please contact Social Prescribing Link Worker for SHS	

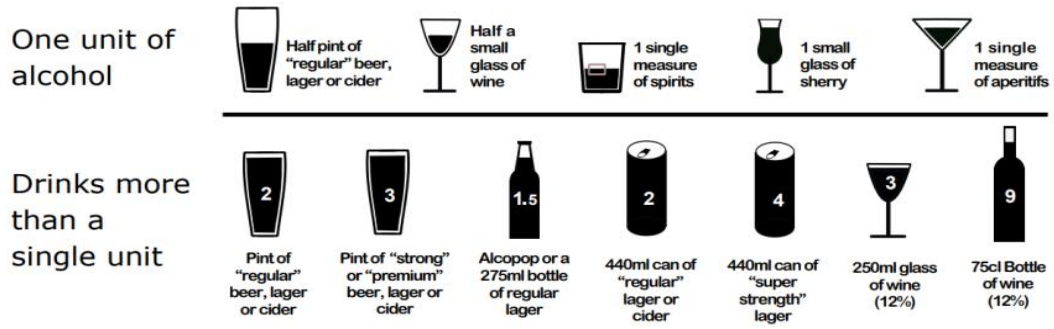
Smoking

Please answer Yes or No				
Have you ever smoked?		If yes, please answer the following questions. If no, please move to the next section.		
Do you smoke now?			If yes, how many cigarettes or grams of tobacco do you smoke each day?	
			If no, when did you quit?	
If you would like help to stop smoking, Smokefreelife Somerset offer a free service www.healthysomerset.co.uk/smokefree/ Or call 01823 356222		For more information: - https://www.nhs.uk/live-well/quit-smoking/nhs-stop-smoking-services-help-you-quit/		

Exercise

How many times a week do you exercise for 30 minutes or more?		Is this exercise light, moderate or vigorous?	

Alcohol



Question	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 times or more per week	
How many units of alcohol do you drink on a typical day when you are drinking?	0 to 2	3 to 4	5 to 6	7 to 9	10 or more	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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 or 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 or 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 or 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 or 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 or 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	
					Total score	

Scoring:
0 to 7 indicates low risk
8 to 15 indicates increasing risk
16 to 19 indicates higher risk
20 or more indicates possible dependence

Please select the following to indicate preferences for us staying connected with you

Consent to receiving information by email: (enter email)	Yes/No
Consent to receiving information by phone: (enter number)	Yes/No
Consent to being contacted via text: (enter number)	Yes/No
I consent to messages being left with a spouse/family member	Yes/No
I would like to receive text appointment reminders	Yes/No
I would like to receive email appointment reminders	Yes/No
I would like to receive important practice announcements and promotions	Yes/No

Summary Care Record System

The NHS Summary Care Record provides a snapshot of some important information:

- **Any allergies you may have**
- **Unexpected reactions to medications**
- **And any prescriptions you have recently received**

The Summary Care Record can only be accessed by authorised clinicians and even then, only if you give permission. Across England it is helping clinicians in Accident and Emergency Departments and 'Out of Hours' health services to give you safe, timely and effective treatment. If you go into hospital, the pharmacy there would be able to check the information above to ensure medications were safe for you. You will be asked if healthcare staff can look at your Summary Care Record every time they need to, unless it is an emergency, for instance if you are unconscious.

You can change your Summary Care record choice at any time by contacting us at the Surgery.

You are strongly recommended to consider this choice to enhance your care. Please tick the box below to show your preference and return it to Reception with your registration forms.

☐ Yes, I want a Summary Care Record ☐ No, I do not want a Summary Care Record

Signed: _____

Date: _____

Children under the age of 16

Patients under 16 years will not receive this form but will have a Summary Care Record created for them and be opted into GP data collection unless their GP surgery is advised otherwise. If you are the parent or guardian of a child, then please either make this information available to them or decide and act on their behalf. Ask the surgery for additional forms if you decide that they should not have a Summary Care Record or need to opt out of the GP data collection scheme.

IMPORTANT INFORMATION ABOUT YOUR REGISTRATION WITH BRUTON SURGERY (please read)

Surgery Processes

- We only accept registrations for patients who live within the practice boundary of 5 miles as the crow flies from the practice premises
- We do not accept repeat medication/prescription requests by telephone, you can request them yourself via the NHS App or the Patient Access App
- The NHS App also displays your vaccination record.
- Please see the surgery website for more details and information about the surgery https://brutonsurgery.nhs.uk/.

How Your Data is Used

- Your summary care record is an electronic record of your valuable information about your health. This data is shared between healthcare providers to enable treatment in the case of emergency. For more information or if you would like to opt out, please follow the link below:
  https://digital.nhs.uk/services/summary-care-records-scr/summary-care-records-scr-information-for-patients

- GP data collection is how NHS digital extracts anonymised data to support healthcare service through planning and research. For more information or if you would like to opt out, please follow the link below:
  National data opt-out - NHS Digital

By submitting this form to Bruton Surgery, you agree:

That you may be contacted from time to time, via email and/or SMS with practice news, advice, about your health and/or appointment reminders.
I have read and understood the above questions and am happy for the practice to contact me regarding the information I have submitted.

Signature: ……

Printed Name: ……

Date: ……