STOKENCHURCH MEDICAL CENTRE

NEW PATIENT MEDICAL QUESTIONNAIRE (ADULT)

All information will be regarded as **CONFIDENTIAL**. Please answer as fully as possible.

DATE: ……

Name: ……

Date of Birth: …….. **Home Tel:** ……..……..

Mobile: ……..…….…..... **Work Tel:** …..…...……

Address: ……...

…… **Post Code:** …….……..

Occupation: …….

Next of Kin: …… **Tel No:** ……..

Are you a *Carer? ……... **Are you cared for by someone?** ..……

(*A carer is: Someone who looks after, or is responsible for a relative, friend or neighbour who, because of illness, frailty, disability or addiction, cannot manage alone)

Name of Carer: ……..…….……..

Address/Contact Telephone Number: ……..……..

……..

Person Cared for: …….

Address/Contact Telephone Number: ……..……..

……..

Marital Status: Single Married Widowed Divorced Separated Partner

Name of anyone else living in your home and their relationship to you

……

Current and previous medical problems and hospital admissions:

Date Major illness/Operation

Current medicines taken:

IT IS IMPORTANT THAT YOU PROVIDE A COPY OF YOUR REPEAT MEDICATION SLIP FROM YOUR PREVIOUS GP AS SOON AS POSSIBLE TO ENSURE CONTINUITY OF SUPPLIES

Allergies to drugs: **…….**

Others: **……..…….**

Immunisations: Please indicate those you have received. Give dates if possible.

	Tetanus	**Polio**	**MMR/Rubella**	**Typhoid**	**Hepatitis A**	**Other**
1st						
2nd						
3rd						
Boosters						

FAMILY HISTORY

Have any of your close family suffered from:-

Stroke Y/N if Yes, who? ……

High Blood Pressure Y/N if Yes, who? ……

Heart Attack Y/N if Yes, who? …….

Angina Y/N if Yes, who? ……..

Diabetes Y/N if Yes, who? ……..

Are there any other illnesses that run in your family? ……..

……

……

HEALTH PROMOTION

What weight are you? …….

What height are you? …….

Do you smoke? …… Yes/No Have you ever smoked …….. Yes/No

Cigarettes Yes/No How many per day ..……..

Cigars Yes/No How many per day ……

Pipe Yes/No oz per week ……

If you have given up please quote year stopped …….

Do you drink alcohol? …….. Yes/No

What is your average weekly alcohol intake?

Spirits Yes/No Amount…….weekly

Wine Yes/No Amount …… weekly

Beer Yes/No Amount ……weekly

Please also complete the following Fast Alcohol Screening Test.

Questions	Scoring System					Your Score
	0	**1**	**2**	**3**	**4**	
How often do you have 6 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only answer the following questions if your answer above is monthly or less						
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative; friend; doctor or health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	

<u>FEMALES</u> (Males please proceed to)**

How many pregnancies have you had? ……

……

……

Are you currently using any form of contraception? …….Yes/No

If so what? ……...

When did you last have a cervical smear? Date……

Was the result normal? …….

If no please give details…….

Have you had a mammogram (breast x-ray)? ……Yes/No

If YES please give date and result …….

……

****APPLICANT'S ETHNIC ORIGIN**

- ☐ White – British
- ☐ White – Irish
- ☐ White – Other
- ☐ Mixed – White Black Caribbean
- ☐ Mixed – any other mixed background
- ☐ Mixed – White & Asian
- ☐ Chinese
- ☐ Decline to State
- ☐ Asian & British Asian – Indian
- ☐ Asian & British Asian – Pakistani
- ☐ Asian & British Asian – Bangladeshi
- ☐ Asian & British Asian – Other Background
- ☐ Black or Black British – Caribbean
- ☐ Black or Black British – Other Background
- ☐ Any Other Ethnic Group

<u>COMMUNICATION</u>:

Are you happy for us to e-mail you with clinical communication? **YES / NO**

Are you happy for us to send sms text messages with clinical communication? **YES / NO**

Patient's signature: ……

SUMMARY CARE RECORDS:

Please see information leaflet attached & for more information go to:
http://www.nhscarerecords.nhs.uk/

Please note unless you complete and return the attached form with your registration forms to opt out of the service this will be deemed as your express consent to a Summary Care Record.

Please choose which version of the Summary Care Record you consent to:-

☐ **Express consent for medication, allergies & adverse reactions only**

☐ **Express consent for medication, allergies & adverse reactions AND additional informaton**

If you wish to opt out of this service please complete the attached form and return it with your registration form.

EMIS ONLINE APPOINTMENTS AND REPEAT MEDICATION REQUEST

To register for this service please go to **https://patient.emisaccess.co.uk/**

ELECTRONIC PRESCRIPITON SERVICE (EPS)

Stokenchurch Medical Centre now uses this service – prescriptions are delivered to the patient's nominated Pharmacy electronically. To register for this service please go to your choice of pharmacy and ask them to register you.

(If you were previously set up for EPS in another area, and no longer want to collect from there, it is important that you change your nominated pharmacy, before requesting medication from Stokenchurch Medical Centre)