HT Practice

New Patient Questionnaire

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Please fill out this form using CAPITAL LETTERS

Patient Details	
Title: Mr ☐ Mrs ☐ Miss ☐ Dr ☐ Other ☐ (Please state)	Address:
First Name:	
Surname:	
Date of Birth:	
Gender:	Postcode:
Occupation:	Home Tel No:
Email:	Mobile No:
Marital Status:	

Ethnic Origin:

☐ White British	☐ White & Black Carribean	☐ Bangladeshi
☐ White Irish	☐ White & Black African	☐ Chinese
☐ Other White	☐ Other Mixed	☐ Do not wish to state
☐ Black Carribean	☐ Other Asian	☐ Other Ethnic Group (Please state)
☐ Black African	☐ Indian	
☐ Other Black	☐ Pakistani	

Next of Kin	
Full name:	Relationship:
Tel No:	Mob No:

Language Support	
What is your first language:	Do you use any of the following:
Do you speak English: ☐ Yes ☐ No	Sign Language: ☐ Yes ☐ No
Interpreter Required: ☐ Yes ☐ No	Hearing Aid: ☐ Yes ☐ No
If yes, which language?:	

Additional Information			
Religion:			
☐ Christian	☐ Muslim	☐ Hindu	☐ Other religion
☐ Buddhist	☐ Jewish	☐ Sikh	(Please state)
☐ No religion	☐ Do not wish to state		

Are you a Military Veteran? ☐ Yes ☐ No	Are you a Carer? ☐ Yes ☐ No
If yes, do you give permission for this to be recorded in your medical records? Yes ☐ No ☐	If yes, who do you care for:

The following drugs are NOT prescribed by HT Practice:

Diazepam

Lorazepam

Nitrazepam

Temazepam

These drugs will only be prescribed if the patient is under the care of the hospital and we have patient records to verify this.

Health Overview		
Height: cms	Weight: kgs	BMI:
Blood Pressure: /	Pulse Rate:	

Smoking Status:

Never smoked ☐ Ex smoker ☐ Current Smoker ☐ How many per day?

Alcohol Status:

Approximate number of alcohol units consumed per week:

How often do you have an alcoholic drink?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ More than 4 times a week

How many units of alcohol do you have on a typical day when you are drinking?

☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 6 or more

How often do you have 6 or more (female) or 8 or more (male) units on one occasion?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily/almost daily

Have you or a close relative ever had any of the following illnesses?:

***Please state nature of relationship**

	You	*Relative		You	*Relative
Asthma			Diabetes		
High BP			Stroke		
Glaucoma			High Cholesterol		
Cancer			Depression		

Other (please state):

Do you consider yourself to have any disabilities?:

☐ Yes ☐ No (Please specify)

Do you have any allergies?:

☐ Yes ☐ No (Please state)

Please provide any medical records/evidence of any previous vaccinations given

Summary Care Record
A Summary Care Record (SCR) is an electronic record of important patient information created from GP medical records. They can be seen and used by authorized staff in other areas of the health and care system involved in your care. **You may also wish to get further information from this website: https://digital.nhs.uk/services/summary-carerecords-scr** **If you DO NOT want a Summary Care Record, please complete the following section:**
☐ **No – I do not wish to have a Summary Care Record (please tick) – I understand that this means, should an emergency arise, healthcare staff will be unable to access information regarding any medication I am taking, any allergies I suffer from or any bad reactions to medicines I have. I understand that I can opt back in at any time by contacting my GP practice.**

Communication
Text Messaging: If you have a mobile phone number you can receive messages regarding appointments confirmations, appointment reminders, health campaigns (eg. flu jab). Please tick the following if you wish to opt out to this service:
☐ **Yes – I do not want HT Practice to send text messages to my mobile phone number**
You can also download the app to receive the same messages: https://www.mjog.com/messenger/

Electronic Prescriptions
The electronic prescription service (EPS) is an NHS service. Please read the dedicated information sheet within the new patient pack for full details. **If you wish to enroll to this service, please complete the following**
☐ **Yes – I have read the EPS information sheet and wish to enroll to the service. My nominated pharmacy is:**

I confirm that I have read and understood all of the above information and give or do not give my consent as indicated in each section.		
Print Name:	**Signature:**	**Date:**