

SURREY LODGE GROUP PRACTICE NEW PATIENT QUESTIONNAIRE

Please complete all questions. If not relevant then please enter None.

Failure to complete the questionnaire in full may lead to delays in registering you.

PLEASE WRITE CLEARLY IN CAPITAL LETTERS.

PERSONAL DETAILS			
Surname/Family Name		Forenames/First Names	
		Date of Birth	
		Sex M/F	
Address (students please use term time address)			
Post Code			
Please provide a contact number. This allows us to contact you should we need to change an appointment or inform you of a test result for example.			
Telephone		Mobile	
Please provide details of your next of kin in the event of an emergency.			
Name and relation		Telephone	
You will be registered with the practice. Please indicate below ONLY if you have a preference which GP you would like to see.			
<input type="checkbox"/> Dr Lynne Enoch	<input type="checkbox"/> Dr Steven Riley	<input type="checkbox"/> Dr Tracey Vell	<input type="checkbox"/> Dr Henry Petrie
<input type="checkbox"/> Dr Selina Dunn			

LIFESTYLE				
What is your average alcohol intake per week? (please tick one) 1 unit = 1/2 pint beer or cider or 1 glass wine or 1 measure spirit				
<input type="checkbox"/> Teetotal/none	<input type="checkbox"/> 1-3 units	<input type="checkbox"/> 4-7 units	<input type="checkbox"/> 8-11 units	<input type="checkbox"/> 12+ units
Have you ever been a regular smoker?			Do you smoke now?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
What did/do you smoke? (please tick all that apply)				
<input type="checkbox"/> Cigarettes	<input type="checkbox"/> Cigars	<input type="checkbox"/> Pipe	<input type="checkbox"/> Other	
How many per day? (please tick one)				
<input type="checkbox"/> 1-5	<input type="checkbox"/> 6-10	<input type="checkbox"/> 11-15	<input type="checkbox"/> 16-20	<input type="checkbox"/> 20+
How often do you exercise? (please tick one)				
<input type="checkbox"/> Daily	<input type="checkbox"/> 2-3 times week	<input type="checkbox"/> Once week	<input type="checkbox"/> 2-3 times month or less	

HEALTH AND FAMILY HISTORY	
Please give dates and details of any operations or major illnesses you have had.	
Please give details of any medications you are taking (including oral contraceptives).	
Please describe any allergies you have to foods, animals, drugs etc.	
Do you suffer from any of the following conditions (please circle all that apply)	
Heart disease Diabetes Epilepsy Thyroid problems Asthma Airways disease High blood pressure	
When was your last cervical/PAP smear test? (females only)	
Date (dd/mm/yyyy)	Result
Weight	Height
If unsure please give approximate values	

RESIDENCY	
Do you live permanently in the UK?	If no, what is the purpose and duration of your stay.
<input type="checkbox"/> Yes <input type="checkbox"/> No	

PLEASE TURN OVER

DATA PROTECTION NOTICE

We will hold (on computer and in written records) and process the personal data you supply to us under the terms of the Data Protection Act 1998. We ask you for personal data so that you can receive proper care and treatment. This information, together with details of your care, is kept because it may be needed if we see you again. We may share relevant personal data with other health professionals such as a referral to a hospital consultant or for national screening programmes. We assume that you will consent to sharing information within the NHS as this is in the interests of your health. We will never disclose any personal data outside of the NHS without your prior written consent. If you would like further information about how your data is processed, or if you would like access to the information we hold about you then you should write to the Data Controller at the practice address.

DECLARATION

I confirm that the information I have provided is accurate and relates to me. I understand that if any of the information is found to be false then I may be asked to find another GP and removed from the practice list.

Signed		Date	
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PLEASE ENSURE THAT YOU HAVE COMPLETED ALL PARTS OF THIS FORM AND ALSO COMPLETED THE ALCOHOL AND ETHNICITY QUESTIONNAIRES

In order to register you must provide documentary evidence of the name and address that you are registering. Acceptable documentation from the lists below must be presented to reception with this form in order to register as a patient. Exceptions will only be made at the discretion of the Practice Manager or a Partner, Reception staff cannot override these requirements.

Acceptable evidence for proof of legal name (originals only):

- birth certificate;
- passport;
- photo card driving licence;
- national identity card;
- Home Office identity card.

Acceptable evidence for proof of address (originals only bearing the patient's name and dated in the last three months and showing the address being registered):

- statement from a financial institution (bank, building society, credit card or mortgage lender);
- bill from a utility company (gas, electric, water or fixed line telephone provider);
- council tax bill;
- letter confirming entitlement to housing benefit, council tax benefit or tax credits;
- letter from the Home Office in relation to an application for asylum or appeal;
- letter from the educational establishment that you are currently attending.

FOR COMPLETION BY PRACTICE STAFF ONLY**Check that name, date of birth and address match on all documents**

<i>Proof of name presented (must be original document)</i>	<i>Proof of address presented (must be original in last 3 months)</i>
Birth certificate <input type="checkbox"/>	Statement from financial institution <input type="checkbox"/>
Passport <input type="checkbox"/>	Utility bill (gas, electric, water, fixed line phone) <input type="checkbox"/>
Photo card driving licence <input type="checkbox"/>	Council tax bill <input type="checkbox"/>
National identity card <input type="checkbox"/>	Housing/Council tax benefit or tax credits <input type="checkbox"/>
Home Office identity card <input type="checkbox"/>	Home Office letter <input type="checkbox"/>
	Educational institute letter <input type="checkbox"/>

I have checked both of the above documents and confirm that they meet practice requirements.

Signed:		Date:	
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Alcohol screening questionnaire

The government has introduced a programme to tackle alcohol misuse and we are therefore required to ask you to answer the following questions.

Instructions

Choose your answer to each question and note the number of points from the very top row. Write the number of points as your score in the right hand column for each question.

Name	
Date of birth	

If you do not wish to complete this questionnaire then please sign here	
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Points	0	1	2	3	4	Score
How often do you have a drink that contains alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many drinks did you have on a typical day when you were drinking in the past year?	1-2	3-4	5-6	7-9	10+	
How often did you have six or more drinks on one occasion in the past year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

If your score from the above three questions add up to 3 or more then please also answer the questions below

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 drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed a first 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 someone 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 or a doctor or another 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	

Please turn over

Ethnicity recording

We ask you for information about your ethnicity to help provide better care. The management of certain conditions is different depending on ethnic background and it is therefore useful to us to have this data recorded so that we can provide the most suitable treatments.

Please tick one of the following to indicate the ethnic category you associate yourself with.

- | | |
|--|---|
| <input type="checkbox"/> White British | <input type="checkbox"/> Black British |
| <input type="checkbox"/> White Irish | <input type="checkbox"/> Black and White |
| <input type="checkbox"/> White European | <input type="checkbox"/> Black and Asian |
| <input type="checkbox"/> White and Black African | <input type="checkbox"/> Black and Chinese |
| <input type="checkbox"/> White and Black Caribbean | <input type="checkbox"/> Mixed Black |
| <input type="checkbox"/> White and Asian | <input type="checkbox"/> Other Black |
| <input type="checkbox"/> White and Chinese | |
| <input type="checkbox"/> Other White | <input type="checkbox"/> British Asian |
| <input type="checkbox"/> Mixed British | <input type="checkbox"/> Asian and Chinese |
| | <input type="checkbox"/> Mixed Asian |
| <input type="checkbox"/> African | <input type="checkbox"/> Indian or British Indian |
| <input type="checkbox"/> Caribbean | <input type="checkbox"/> Pakistani or British Pakistani |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Bangladeshi or British Bangladeshi |
| <input type="checkbox"/> Other mixed | <input type="checkbox"/> Other Asian |
| <input type="checkbox"/> I do not wish to state my ethnicity | |

Please turn over