FAIRFIELD SURGERY –BURWASH

You will be registered with Dr This will be your “Named GP”)

Please take the time to fill in this questionnaire (print clearly)

**About You**

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| --- | --- | --- | --- |
| Forename(s)  |  | Title (Mr/Mrs/etc) |  |
| Surname |  | Date of Birth |  |
| Address |  | Town, County &Country of Birth |  |
| Post Code |  | NHS Number |
| Tel/Mob Number/s |  | Occupation |  |
| Marital Status  | Single/Married/Widowed/ Co-Habiting  | Name of Spouse or Partner |  |
| Your Ethnic Origin |  | Your First Language |  |

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| **Do you have any Communication Needs?**  |
| **No** – [ ] Tick box & go to next section**Yes** - [ ] please give details | Do you have support? (i.e. advocate/note taker/sign language) | Do you need specific format?(i.e. large print/easyread/braille) |
| Preferred contact method?(i.e. text, letter)  | Do you need support?i.e. advocate/note taker/interpreter |
| Mobility | Fully mobile [ ] Housebound [ ]Mobile with aid [ ] (i.e. wheelchair, frame/sticks/assistance) |

**1. Next of Kin - must be spouse or relative 2. Other Contact in Emergency**

**(not partner unless civil ceremony)**

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| --- | --- | --- | --- |
| Full Name  |  | Full Name |  |
| Address  |  | Address |  |
| Relationship to you |  | Relationship to you |  |
| Contact No.  |  | Contact No. |  |

**Carer Details**

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| **Are you a Carer/Young Carer? If you are a Carer would you like to be added to the Practice’s register to receive regular information and support.** |
| Yes  | No  |
| (If yes) I care for (name): |
| Relationship to you: |  |
| **The person I care for has:** | Dementia | PhysicalDisability | MentalIllness | ChronicDisease |

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| **Registration Documentation – Please bring to the surgery for us to see one of the following documents from Parts 1 & 2 before we accept you as a patient**  |
| **1.** **Proof of Identity** - *Please circle which one you are providing* |
| **UK Nationals** | Photo Driving Licence, Birth Certificate, Marriage Certificate, Medical Card, Passport, N.I. Number, Photo Card, Evidence of Benefit entitlement  |
| **EuropeDan Economic Area** | Passport, European Health Card (EHIC not E111) |
| **Non UK Nationals*****Date Entered Country*** | Visa, Residence Permit, Work Permit, Student Visa or letter from educational establishment |
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| **2.** **Proof of Address** – *Please circle which one you are providing* |
|  | Local Authority Rent Card, Paid Utility Bill (Gas/Electric/Phone including mobile), Bank Statement, Council Tax Documents |

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| **For surgery use:** |  |
| **ID provided (please state type)** |  |
| **Signed and dated (by surgery staff member)** |  |

**Health Questionnaire Name: / DOB\_\_\_\_\_\_\_**

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| We offer a **New Patient Health Check** for every patient we take on. ***Please make sure you have a date for yours and PLEASE BRING A URINE SAMPLE*** on the day – (please ask at Reception). | Date of NPHC………………………………. |

Answer as fully as possible if data known; if you need anything explained please do ask.

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| --- | --- | --- | --- |
| **Height** | **Weight** | **Waist measurement** | **Blood Pressure** |
|  |  |  |  |

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| --- | --- |
| **Smoking Status** | Never Smoked [ ] Ex-Smoker [ ] (when did you stop) …………….….Current Smoker [ ] How many cigarettes per day on average ……………. |
| **Alcohol** | If you drink – how much per week …………………………… |
| **Diet** | Are you on any special diet (i.e. weight loss, gluten free, vegan) ……………………..  |
| **Exercise**  | Do you do regular exercise? What sort………………………………………………………..How many times per week?............................................................................................ |

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| --- | --- | --- | --- |
| **Date of Last flu vaccination** |  | **Date of last pneumonia vacc** |  |

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| Do **YOU** suffer from/ have you suffered from any of the following: | If yes Date or Year | Do **YOU** suffer from/ have you suffered from any of the following: | If yes Date or Year |
| Heart Attack |  | Liver disease or splenectomy |  |
| Angina |  | Kidney Disease |  |
| High Blood Pressure |  | Chronic lung Disease |  |
| Coronary Artery Operations |  | Asthma |  |
| Stroke/ CVA/ TIA |  | Osteoporosis |  |
| DVT or pulmonary embolism |  | Psychiatric or Emotional Problem |  |
| Thyroid Disease |  | Other Operations or Accidents |  |
| Diabetes – controlled by dietDiabetes – controlled by insulinDiabetes – controlled by tablets |  | Cancer -Please give details; |  |
| Do you have any drug/non-drug allergies? |  | Do you suffer from any other medical condition? |  |

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| Has any **family** member had / developed? | If yes - Who | Cancer – (especially of breast, ovary or bowel) |  |
| heart disease before the age of 60 |  |
| heart disease later than 60 |  | Been diabetic |  |
| Had strokes |  | Had or got asthma |  |

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| Cervical Smear Record (Women over 16 only) |
| When do you think your last smear was |  | Do you use any form of contraception | Yes / No |
| Have you had a hysterectomy? |  | If yes – which one |
| How many children have you had? |  | If a coil when was it fitted? |  |

**Repeat Medications** Please list below all repeat medications prescribed to you

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| --- | --- | --- | --- | --- | --- |
| Name of Medicine | Strength | Dosage | Name of Medicine | Strength | Dosage |
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You will need to see a Doctor the first time you require a repeat of your medication. Please make an appointment to do this, bringing your order slip or current medication with you. Once you have seen your Doctor you will then be able to order your repeat medication on a monthly basis. We appreciate that all your medication does not become due at the same time. However, we shall attempt to address this problem by adjusting the number of your tablets to allow you to order monthly.

There will, of course, be certain medication for which this will not be possible I.e.; Asthma/Diabetic medication and pain killers and we are in no way suggesting that a patient shall be without medication they need but it would be most helpful, when possible, to keep to a monthly request.

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| **Prescriptions:** If you live more than one mile from your nearest chemist (as the crow flies); you can collect your medication from the surgery. Would you like to collect your medication from the surgery if possible? | **Yes - [ ] No - [ ]** |

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| **Summary Care Record**Do you wish your clinical information to be added to the NHS Summary Care Record? | **Yes - [ ] \*No - [ ]****\*If your answer is NO, you will need to complete an opt-out form. Please ask the receptionist for this.** |

\*If you are a smoker we would advise you to stop. If you require further advice on helping to quit smoking, please ask the Practice Nurse or GP who will be happy refer to the quit smoking support services.

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| FOR OFFICE USE ONLY  |  |
| Patient informed of usual GP  | YES / NO  |
| Patient coded as having GP allocated ( 9NN60 ) | YES / NO  |
| Checked is patient is carer  | YES they are No they are not  |
| If they are a carer have you coded ( 918G)  | Code put on Yes / No  |