**Mytham Road**

**Little Lever Health Centre Bolton**

**Dr Jain & Dr Subramanian BL3 1JF Tel: 01204 462988**

**NEW PATIENT QUESTIONNAIRE**

New patients must provide TWO documents of ID. One item of photo ID along with a document containing the patients address. Please print clearly and answer as many questions as you can. All information provided is confidential.

**Your contact details:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Title** |  | **Marital Status:** |  |
| **Surname** |  | **Forename** |  |
| **Date of Birth** |  | **Occupation** |  |
| **Home address:**  **Post code:** | | | |
| **Tel number** |  | **Work telephone** |  |
| **Mobile number** |  | **Email** |  |

**Next of kin:**

|  |  |  |
| --- | --- | --- |
| **Are you a Military Veteran?** (If you have served in the UK armed forces). | **Yes** | **NO** |

|  |
| --- |
| **Please give name, address, telephone number and relationship of your next of kin.** |
|  |

|  |  |
| --- | --- |
| **Are you a carer?** If yes please state who you care for. |  |

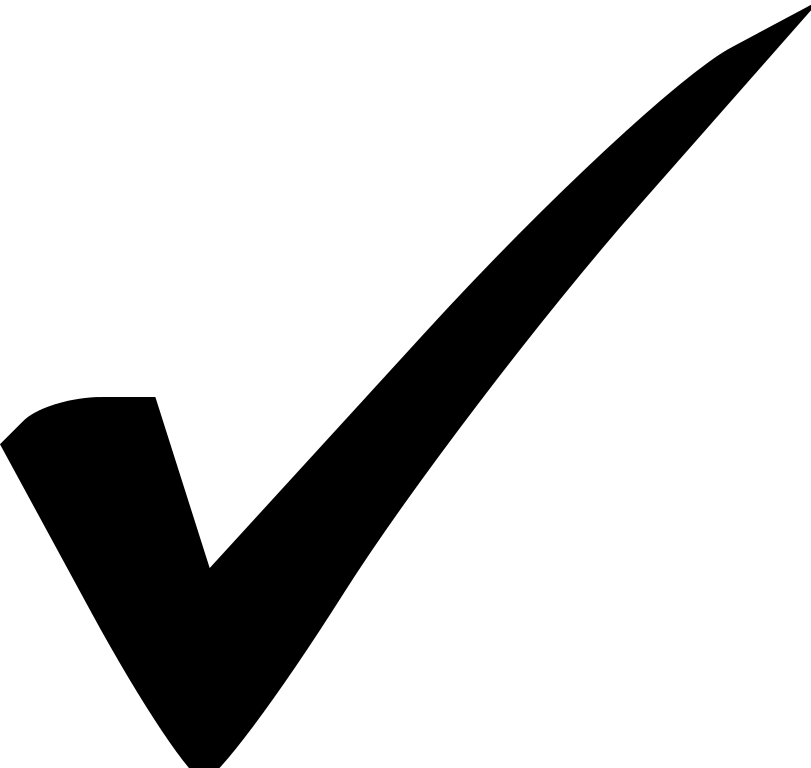
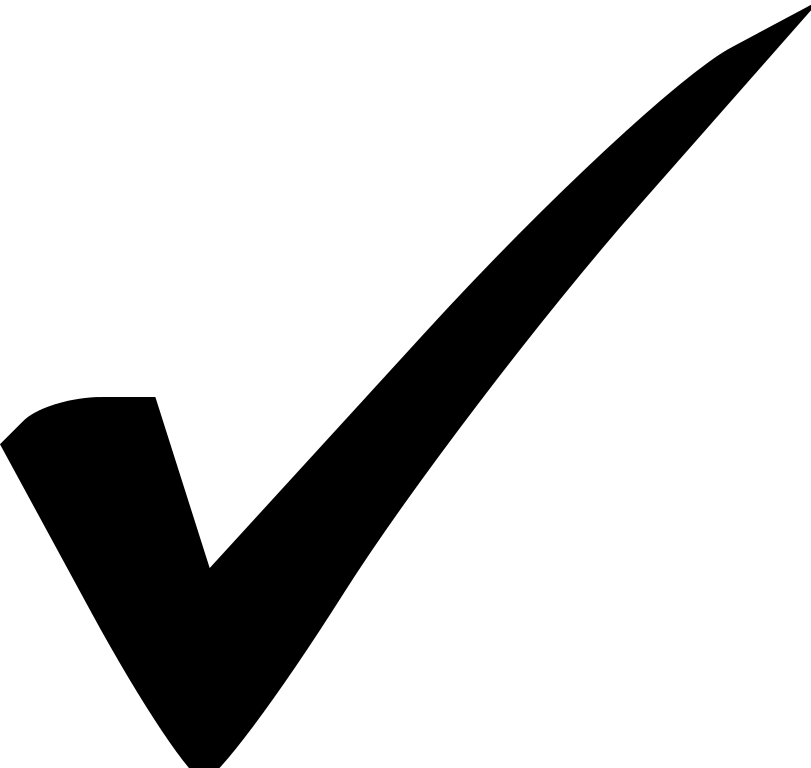
**Information about you:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Height:** |  | **Weight:** |  | |
| **Main Language:** |  | **Registered disabled:** | **Yes** | **No** |
| **Do you have any mobility problems?** |  |  |  | |

|  |  |
| --- | --- |
| **What is your religion?** |  |

**Medical information:**

Please indicate below any serious illnesses for yourself. (Please tick appropriate)

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|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Epilepsy** | |  | **Blindness/ glaucoma** | | |
|  | **High blood pressure** | |  | **Diabetes** | | |
|  | **Heart attack/ stroke** | |  | **Asthma** | | |
|  | **Cancer** | |  | **COPD** | | |
|  | **Eczema/ hay fever** | |  | **OCD** | | |
|  | **Anxiety** | |  | **Depression** | | |
|  | **Bipolar** | |  | **Heart disease** | | |
|  |  | |  |  | | |
| **Do you have any other mental health issues? If yes please give details.** | | |  | | | |
| **Are you receiving or have you received any treatment of therapy? If yes please give details.** | | |  | | | |
|  | | **Are you a smoker? If yes how many per day?** |  | **Never smoked.** |  | **Ex- smoker.** |
| **Are you allergic to any medications? e.g. penicillin? If yes please state** | | |  | | | |

**Screening:** Have you had cervical/breast/chest/bowel screening in the last 5 years?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Type of screening** |  | **Date of screening** |  | **Result** |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Pregnancy/ Maternity:**

**Pregnant 🞎**

**Estimated Delivery Date:……………………………………….**

**Family history:**

|  |
| --- |
| **Please state any serious illnesses in particular heart disease, strokes, high blood pressure, diabetes or any inherited diseases and the relationship to yourself (e.g. Mother / Father)** |
|  |

**Ethnicity**

Which of the following best describes how you think of yourself? Please tick one option

|  |  |  |  |
| --- | --- | --- | --- |
| Asian or Asian British | Black or Black British | Mixed/Multiple Ethnicity | White |
| Bangladeshi | African | Asian and White | White British, English, Northern Irish, Scottish or Welsh |
| Chinese | Caribbean | Black African and White | White Irish |
| Indian |  | Black Caribbean and White | GRT |
| Pakistani |  |  |  |
| Any other ethnic Group *(Please state)* | | | |

**Sexual Orientation**

Which of the following options best describes how you think of yourself?

Woman (including trans woman)  Man (including trans man)  Non-binary

|  |  |
| --- | --- |
| In another way  *Please state):* |  |

Is your gender identity the same as the gender you were given at birth?

Yes  No

Which of the following options best describes how you think of yourself?

Lesbian  Bisexual  Gay  Heterosexual/Straight

|  |  |
| --- | --- |
| In another way *(Please state)* |  |

**Alcohol consumption:**

**Please tick as appropriate if you drink alcohol:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| * How often do you have a drink containing alcohol? | Never | Monthly or less | 2-4 Times a month | 2-3 Times a week | 4+ Times a week |
| * How many units of alcohol do you have on a typical day ? | 1 - 2 | 3 - 4 | 5 - 6 | 7 - 9 | 10 or more |
| * How often do you have 6 or more units(female) or 8 or more (male) at any one time? | Never | Less than Monthly | Monthly | Weekly | Daily / Almost daily |

**Prescription information:**

Do you take regular medication? Please attach a copy of your **repeat** prescription**.**

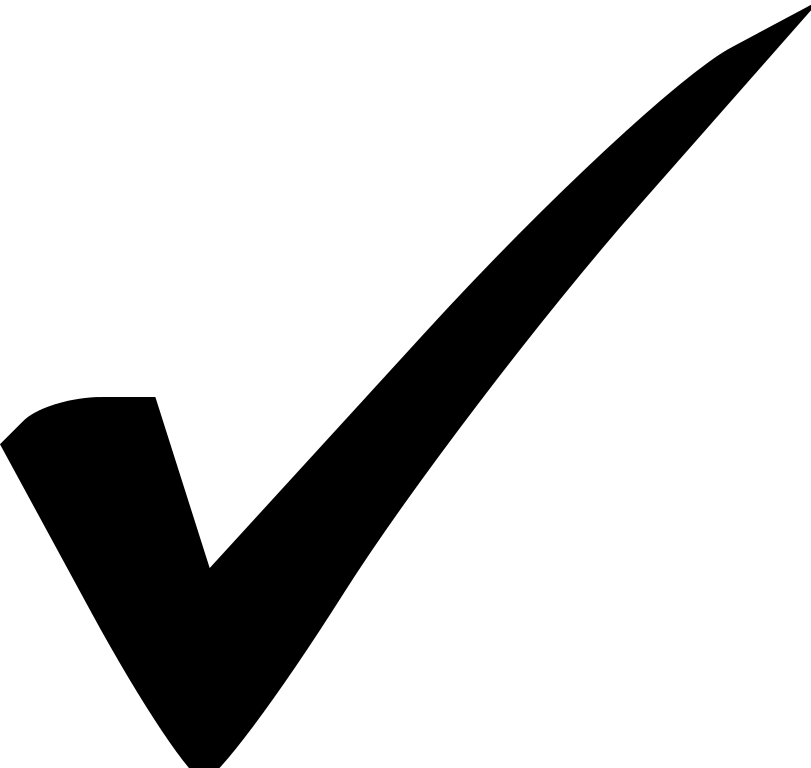
**Accessible information standard**

Do you have any communication / information needs relating to a disability or sensory loss and if so what are they? Please indicate below

|  |  |
| --- | --- |
| **Blind or have some visual loss** |  |
| **Deaf or have some hearing loss** |  |
| **Deafblind** |  |
| **Learning disability** |  |
| **Aphasia** |  |
| **Mental health conditions which affects your ability to communicate** |  |
| **Autism** |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **C:\Users\courtney.salmon\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\DC22TC6N\Check_mark_23x20_02.svg[1].pngWhich of the following options best describes how you think of yourself?** | | **C:\Users\courtney.salmon\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\DC22TC6N\Check_mark_23x20_02.svg[1].pngWhich of the following options best describes how you think of yourself?** | | | |
| Heterosexual |  | Male (including trans man) | | |  |
| Lesbian |  | Female (including trans woman) | | |  |
| Bisexual |  | Non-binary | | |  |
| In another way (Please state below) | | In another way (Please state below) | | | |
|  | |  | | | |
| **Is your gender identity the same as the gender you were given at birth?** | | **Yes** |  | **No** |  |

**Communication by text message consent:**

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|  |  |
| --- | --- |
| **SMS Consent** | **Tick Consent Preference** |
| Consent given for communication by SMS text messaging |  |
| Declined consent for communication by SMS text messaging |  |

**Please Read and sign below.**

|  |  |
| --- | --- |
| **I have completed this form to the best of my knowledge.** | |
| Name of person completing this form: |  |
| Signature: | Date: |

**Summary Care Record**

**(Please read all 3 sections and fill in your preference in the box below)**

**Summary Care Record**

* Your summary care record contains important information about and medicines you are taking, any allergies you may have and any bad reactions to medicines you may have experienced previously.
* Allows authorised healthcare professionals to have access to this information will improve decision making by doctors and has prevented mistakes being made when patients are being cared for in a different care setting.
* Your summary care record includes your name, address, D.O.B and your NHS number to help identify you correctly.
* Healthcare staff will have access to this information- so that they can provide safer care whenever or wherever you need it, anywhere in England.

**Enhanced Summary Care Record (recommended for patients over 65 & with complex medical needs)**

We are required to offer to share your enhanced summary care record, this includes all information in the summary care record as well as any significant medical diagnoses, any significant treatments (e.g. immunisations and seasonal influenza dates) and any significant investigations (e.g. Gastroscopy and MRI scans results). If you would to consent to this, then tick in the box below.

**Opt –Out of Summary care Records**

**If you do not wish to consent to Summary care Record and want to opt out, please speak to Reception staff and fill in a form.**

|  |  |  |
| --- | --- | --- |
| Type of Summary Care Record | Level of Consent | **C:\Users\courtney.salmon\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\DC22TC6N\Check_mark_23x20_02.svg[1].png**Please select and Tick to Consent |
| Summary Care record | Express consent for medication, allergies, adverse reactions only |  |
| Enhanced Summary Care record( Additional information) | Express consent for medication, allergies, adverse reactions and additional information |  |
| Opt Out of Summary care Record | Opt out – patient does not want a summary care record. |  |

**Allocated Named GP for ALL patients**

Dear Patient,

We are required to allocate every patient with a named GP.

If you would like to know who your named GP is, please speak to reception.

**Please note that although you will be allocated a named GP, you are still able to see ANY GP within the practice.**

**Office use only:**

Photographic ID must be photocopied to confirm the patient’s identity. The ID and this document must be scanned into the patient record for future reference and then given to the Practice Manager.

Two forms of ID are needed:

1 – Photo I.D. (Passport/Driving License) Shown: Copied

2 – Utility Bill showing patients current address (within last 3 months) Copied

Taken by (Staff name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Manager to Complete:**

Check to add Appropriate coding( for summary care record, Audit C, etc)