NEW PATIENT QUESTIONNAIRE

This form is to register as an NHS patient with Merchiston Surgery. Please complete in **block capitals.**

Date: ……. Surname: ……. First name: …….

Address: …….

……Post code: …….....

Telephone No: Home: …… Work: …….. Mobile: …….....

Email Address: …….

Date of Birth: …… Marital Status: …… Occupation: ……...

Summary Care Record (SCR) - SCRs allow Healthcare staff quicker access to important information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines that you have had. This means they can provide safer care during an emergency when your GP is closed or when you are away from home in another part of England. If you want a SCR you do not have to do anything it will happen automatically. If you do not want a SCR you must complete the Opt Out form in Reception.

Are you registered disabled? (please circle) NO / YES
If YES, please state type of disability ……

Do you have a carer? (please circle) NO / YES

Are you a carer? (please circle) NO / YES

General Practice Extraction Service (GPES) - The Health and Social Care Information Centre (HSCIC) was empowered by the Health and Social Care Act 2012 to extract selected data from healthcare providers to support healthcare at national level. The aim of sharing this information is to improve understanding, locally and nationally, of the most important health needs and the quality of treatment and care provided by local health services, such as supporting studies that identify patterns in diseases, responses to different treatments and potential solutions. Only the minimum amount of information is used. The data is extracted using Read Codes and includes prescribing data but no free text. The confidentiality and security of patient information is of paramount importance and strict rules are in place to protect the privacy of patients. However, if you do not want to share your information via GPES you must complete the Opt Out form available from Reception.

Ethnic Group: (please circle)

White - British Irish Other White Background (please specify) …….

Mixed – White & Black Caribbean White & Black African White & Asian

Other mixed background (please specify) …….

Asian or British Asian – Indian Pakistani Bangladeshi Other Asian (please specify) ……

Black or Black British - Caribbean African Other Black background (please specify) ……. …..

Chinese Any other ethnic group (please specify) …… 1st Language ……

GENERAL MEDICAL HISTORY

Serious or chronic illnesses (please circle)

Blood Pressure: YES / NO Diabetes: YES / NO Heart Disease: YES /NO

Epilepsy: YES / NO Asthma: YES / NO Stroke: YES / NO

COPD: YES / NO Depression: YES / NO Cancer: YES / NO

Kidney Disease: YES / NO Glaucoma: YES / NO Severe Mental Illness/Issues: YES / NO

Other serious / chronic illnesses or operations : ……..

……...

FAMILY HISTORY

Is there a family history of:

High blood pressure: YES / NO Heart Disease: YES / NO Diabetes: YES / NO

Glaucoma: YES / NO Stroke: YES / NO Asthma: YES / NO

Cancer: YES / NO Depression: YES / NO

SMOKING

Do you smoke? YES / NO (please circle) Never smoked Ex-smoker

What do you smoke and how much? **Are you interested in Smoking Cessation? YES/NO**

ALCOHOL

How much on average do you drink in a week? …….
(1 unit = ½ pint of beer, 1 glass of wine, or a pub measure of spirits)

DIET

Do you add salt to your food after cooking? Yes/No
Do you have a varied diet including milk, meat, vegetables and fruit? Yes/No
Has your Cholesterol been checked in the last 2 years?

DRUGS AND MEDICINES

What medicines / tablets are you taking? (including contraceptives for females)

……...

……...

Are you allergic to medicines / tablets or anything else (eg nuts)? If so, which ones:……

……..

HEALTH SCREEN

Current Height: ……..… Current Weight: ……..… Current Waist measurement: …….....

FEMALE PATIENTS ONLY

Have you ever had a Cervical Smear? (please circle) YES / NO

When was your last cervical smear test? ……

Who did it? (please circle) GP Clinic Hospital

What method of contraception do you use at present? (please circle) Pill Coil

Injection Implant

Have you any children? (give ages) …….

Have you had any miscarriages? ……..

Have you had a termination of pregnancy? …….

Have you had a hysterectomy? YES / NO Date: ……..

Date of last mammogram: ……

VACCINATIONS

Which vaccinations have you had and when? …….

Diphtheria..... Polio…….. Tetanus…….. Measles ……..

HIB …… Hepatitis A …….. Hepatitis B …….MMR ……..

German Measles / Rubella ……..…Whooping Cough / Pertussis…..…… Meningitis…….

Typhoid …….. BCG …….. Yellow Fever …….. Influenza ……...

HIB …… Pneumococcal …….. Others ……...

Do you have private medical insurance? YES / NO

Military Veteran? Service RN/Army/RAF Service No ……

Enlistment Date…… Discharge Date …….

General Practice Physical Activity Questionnaire

1. Please tell us the type and amount of physical activity involved in your work.

		Please mark one box only
a	I am not in employment (eg: retired, retired for health reasons, unemployed, full-time carer etc.)	
b	I spend most of my time at work sitting (such as in an office)	
c	I spend most of my time at work standing or walking. However, my work does not require much intense physical effort (eg: shop assistant, hairdresser, security guard, childminder etc.)	
d	My work involves definite physical effort including handling heavy objects and use of tools (eg: plumber, electrician, carpenter, hospital nurse, gardener, postal delivery workers etc.)	
e	My work involves vigorous physical activity including handling of very heavy objects (eg: scaffolder, construction worker, refuse collector, etc)	

2. During the *last week*, how many hours did you spend on each of the following activities? *Please answer whether you are in employment or not*

Please mark one box only on each row

		None	Some but less than 1 hour	1 hour but less than 3 hours	3 hours or more
a	Physical exercise such as swimming, jogging, aerobics, football, tennis, gym workout etc				
b	Cycling, including cycling to work and during leisure time				
c	Walking, including walking to work, shopping, for pleasure etc.				
d	Housework/Childcare				
e	Gardening/DIY				

3. How would you describe your usual walking pace? Please mark one box only.

Slow pace (ie less than 3 mph)	
Brisk pace	
Steady average pace	
Fast pace (ie over 4 mph)	

Thank you for taking the time to completing this questionnaire The information will help the doctor to make an initial assessment of your health which will help in your future treatment.