New Patient Registration Questionnaire

Adult (Age 16 and over)

Please write in BLOCK CAPITALS.

Full Name: Date of Birth:	Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms Other (please state):
Please state your birth gender? ☐ Male ☐ Female Is your gender identity the same as the sex you were assigned at birth? ☐ Yes ☐ No ☐ Prefer not to say	Marital status: ☐ Single ☐ Widowed ☐ Married ☐ Separated ☐ Divorced ☐ Co-Habiting
NEXT OF KIN	
Name: Relationship to you:	Contact Details:
Do you have a Carer? ☐ Yes ☐ No – If yes, please give carer's details	
Name:	Contact Details:
CONTACT DETAILS	
Email: Wherever possible we prefer to send out information via email, this will include your new patient registration information and your Patient Access PIN document, should you choose to sign up to the service. Are you happy to receive emails from us? ☐ Yes ☐ No	Mobile: We offer an appointment reminder SMS messaging system. This will also include general health information and Practice information such as changes to opening times, simple health status questions and recalling patients for chronic disease management. Are you happy to receive SMS messages from us? ☐ Yes ☐ No
Please state your preferred method of contact: ☐ Email ☐ SMS (text) ☐ Mobile Tele. ☐ Home Tele (please state)……	

ONLINE SERVICES

Patient Access and NHS app

We offer online services to all patients, this can be accessed via Patient Access or the NHS app. This allows you to;

- Order repeat prescriptions
- Change your contact details
- View your full medical record (from date of registration onwards)

If you wish to subscribe to this service, please complete the Online Registration form on page 6.

Ask First

We work closely with Ask First enabling patients to perform the following tasks;

- Check your symptoms
- Book appointments
- Make general enquiries / administrative requests
- Find local services

You can download the app in your app store (iOS) or Google Play (Android) by searching 'Ask First'

PREVIOUS DETAILS

So we can ensure that we have your full medical record, please provide us with any previous names you may have held, your last three addresses in the UK and your last three addresses (if applicable).

It is vital that we have your full medical record, this is important so we can maintain screening programmes, provide you with the best care and keep your medical records complete.

Primary Care Service England (PCSE) will pause your registration with the practice if they find a possible match to your demographics on the NHS Spine, therefore providing us with this information now can prevent this from happening.

PREVIOUS NAME(S):

PREVIOUS ADDRESS(ES):

PREVIOUS GP PRACTICE(S):

Have you ever served in the UK armed forces or were registered with a Ministry of Defence GP in the UK or Overseas?

☐ Yes ☐ No ☐ Prefer not to say

If yes, please state which:

(if you were given a FMED133A or FMED31 form when you left the UK armed forces, you should give this to your GP surgery)

PUBLIC HEALTH STATISTICS

Your Religion

☐ Buddhist	☐ Catholic	☐ Christian
☐ Hindu	☐ Jehovah's Witness	☐ Jewish
☐ Muslim	☐ No religion	☐ Other:

Your Ethnic Origin

☐ White British	☐ White Irish	☐ White Other	☐ Black Caribbean / British
☐ Black African / British	☐ Other Black Background	☐ Indian / British Indian	☐ Pakistani / British
☐ Arabic	☐ Bangladeshi / British	☐ Chinese	☐ Other Asian Background
☐ Other Mixed Background	☐ Other, please state:		☐ Ethnic Category Refused

What is your main spoken language?
Please state below;

Do you speak English? ☐ Yes ☐ No

Do you use an Interpreting app on your phone?
☐ **Yes** ☐ **No**

Do you require an Interpreter present at appointments?
☐ Yes ☐ No

Your Occupation:

HEALTH INFORMATION

Weight:	**Height:**	**How much exercise do you do?** ☐ None ☐ Light ☐ Moderate ☐ Vigorous

Do you smoke?

☐ Non Smoker ☐ Ex-Cigarette Smoker ☐ Current Cigarette Smoker,
☐ Vape with Nicotine ☐ Vape without Nicotine If so, how many a day?……

If you are a smoker and want to STOP please tick here ☐

FAST (Alcohol Screening Test)

Questions	**Scoring system**					**Your score**
	0	1	2	3	4	
How often have you had 6 or more units if female, or 8 or more units if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only answer the following questions if the answer above is Monthly (2) or Less than monthly (1). Stop here if the answer is Never (0), Weekly (3) or Daily (4).						
How often during the last year have you failed to do what was normally expected from you because of your 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	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
Scoring: • A score of 0 on the first question indicates FAST negative. • A total of 1 – 2 on the first question then continue with the next three questions • A total of 3 – 4 on the first question stop screening at first question, this is a positive screen, move to AUDIT below. • An overall total score of 3 or above is FAST positive. Move onto AUDIT below.						**TOTAL**

AUDIT

Questions	**Scoring system**					**Your score**
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Less than monthly	2 -4 times per week	2-3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-8	10+	
How often during the last year have you found that you were not able to stop drinking once you started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic 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	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Scoring: 0-7 Lower Risk 8-15 Increasing Risk 16-19 Higher Risk 20+ Possible dependence						**TOTAL**

MEDICAL BACKGROUND

Do you have any disabilities?

Do you have any drug or food allergies? Please list:

Do you have any personal history of any of the following:

Diabetes Mellitus	☐ Yes	☐ No
Respiratory Disease (inc. Asthma)	☐ Yes	☐ No
Stroke/TIA	☐ Yes	☐ No
Heart Attack (less than 60)	☐ Yes	☐ No
Heart Attack (greater than 60)	☐ Yes	☐ No
Angina	☐ Yes	☐ No
Ongoing Mental Illness	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No

Please state any other health conditions we need to be aware of;

WOMEN ONLY (Aged 25 years and over)

What is the date of your last cervical smear test?

Please provide the result if known:

FAMILY HISTORY

Do you have a family history of any of the following?

Diabetes Mellitus	☐ Yes, relative: _____	☐ No
Heart Attack	☐ Yes, relative: _____	☐ No
Stroke/TIA	☐ Yes, relative: _____	☐ No
Angina	☐ Yes, relative: _____	☐ No
Hypertension (High Blood Pressure)	☐ Yes, relative: _____	☐ No
Breast Cancer	☐ Yes, relative: _____	☐ No
Ovarian Cancer	☐ Yes, relative: _____	☐ No
Bowel Cancer	☐ Yes, relative: _____	☐ No
Lung Cancer	☐ Yes, relative: _____	☐ No

Any other form of Cancer (please state): ……

REPEAT MEDICATIONS

Are you taking any regular medications? If so please give details in the box below;
If you are taking more than 10 repeat medications, please attach a list.

Medication Name (Generic not branded)	**Dosage**	**Quantity left**

! IMPORTANT INFORMATION REGARDING MEDICATIONS !

- You MUST have a medication review before we are able to issue any medications. An appointment will be sent to you via SMS or letter following your registration.
- If you are coming from abroad, please have your medication information translated and provide evidence that you are taking this with your registration papers.

We now send prescriptions electronically (EPS) to a Pharmacy of your choice. Please pick your desired Pharmacy below;

☐ Rowlands	☐ Consult	☐ Tesco Tring Road	☐ Tesco Broadfields
☐ Boots Hale Leys	☐ Boots Walton Court	☐ Morrisons	☐ Lansdale
☐ Hampden Gardens	☐ Buckingham Park	☐ Lloyds Bedgrove	☐ Lloyds Meadowcroft
☐ Pharmacy 2 U	☐ Other …….		

OTHER INFORMATION	
Do you have a "Living Will"? *A statement which explains what medical treatment you would not want in the future*	☐ Yes – Please provide a copy ☐ No
Do you have a DNACPR in place? *Resuscitation Status*	☐ Yes – Please provide a copy ☐ No
Have you appointed a Power of Attorney? *Legal document naming a person to act on your behalf regarding your health and welfare*	☐ Yes – Please provide a copy ☐ No

POPLAR GROVE PRACTICE, MEADOW WAY,
AYLESBURY, BUCKS, HP20 1XB

Patient Online: registration form Access to GP online services

Name			
Date of birth			
Address			
Postcode			
Email address			
Telephone number		Mobile number	

Available at this GP Practice from 1st April 2016. Existing patients will be able to see their medical record items entered on/after 01/04/2016. New patients from date of registration onwards.

I wish to access my medical record online and understand and agree with each statement (please tick)

1. I will be responsible for the security of the information that I see or download	☐
2. If I choose to share my information with anyone else, this is at my own risk	☐
3. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement.	☐
4. If I see information in my record that it not about me or is inaccurate, I will log out immediately and contact the practice as per process available on their website.	☐

Signature		Date	

For practice use only:

Identity verified through (tick all that apply)	Vouching ☐ Vouching with information in record ☐ Photo ID ☐ Proof of residence ☐	Name of verifier	Date
Name of person who created account			
Date account created			
Date linkage key sent			