

BARNARD CASTLE SURGERY

NEW PATIENT REGISTRATION HEALTH QUESTIONNAIRE

To register with the Practice please complete this questionnaire as fully as possible. The information will help us meet your healthcare needs. **Please bring the completed form with proof of identity to reception.**

As your medical notes may take some time to reach us, we would like to take this opportunity of inviting you to make a 20 minute appointment (40 minutes for a family) for a New Patient Check with our Health Care Assistant. During this appointment she will make a note of medical problems and check your current state of health. We would be grateful if you could fill in the questionnaire before the appointment and if you could bring a urine sample with you for testing (sample bottles available from the reception desk at the Surgery).

To make an appointment please telephone 01833 690408.

Your Contact Details

Title	<input type="text"/>	Date of Birth	<input type="text"/>
Surname	<input type="text"/>	NHS Number	<input type="text"/>
First Name(s)	<input type="text"/>	Sex	<input type="text"/>
Preferred Calling Name	<input type="text"/>	Occupation	<input type="text"/>
Previous Surname	<input type="text"/>	Marital Status	<input type="text"/>
Home Address	<input type="text"/>		
Postcode	<input type="text"/>		
Home Telephone	<input type="text"/>	Work Telephone	<input type="text"/>
Mobile Telephone	<input type="text"/>	Email	<input type="text"/>
Next of Kin	<input type="text"/>	Relationship to Patient	<input type="text"/>
Next of Kin Address	<input type="text"/>		
Next of Kin Contact Number	<input type="text"/>		

Previous GP

Name and Address of Previous GP

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Proof of Identity and Address Provided

A combination of the following can be accepted as identification (it is preferable that one item of photo ID is seen, along with one document containing your address):

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Birth Certificate | <input type="checkbox"/> Driving Licence | <input type="checkbox"/> Passport | <input type="checkbox"/> Utility Bill |
| <input type="checkbox"/> Allowance Book | <input type="checkbox"/> Solicitor's Letter | <input type="checkbox"/> Offer of Tenancy | <input type="checkbox"/> Medical Card |
| <input type="checkbox"/> Marriage Certificate | <input type="checkbox"/> Payslip / P45 | <input type="checkbox"/> Bank / Building Society Cards / Statements | <input type="checkbox"/> National Insurance Number Card |

Other

On-line Services

Would you like to register for our on-line appointment booking and prescription ordering service? www.barnardcastlesurgery.co.uk Yes No

Medical Information

Have you ever suffered from? (Tick as appropriate)

- | | | | |
|---------------------|--|--------------------|--|
| Epilepsy | Yes <input type="checkbox"/> No <input type="checkbox"/> | Blindness/Glaucoma | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| High Blood Pressure | Yes <input type="checkbox"/> No <input type="checkbox"/> | Diabetes | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Heart Attack/Stroke | Yes <input type="checkbox"/> No <input type="checkbox"/> | Depression | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Cancer | Yes <input type="checkbox"/> No <input type="checkbox"/> | Asthma | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Eczema/Hay Fever | Yes <input type="checkbox"/> No <input type="checkbox"/> | COPD | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Anxiety | Yes <input type="checkbox"/> No <input type="checkbox"/> | Bipolar Disorder | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| OCD | Yes <input type="checkbox"/> No <input type="checkbox"/> | | |

Please list any other serious illnesses / operations / accidents / disability (and for women any pregnancies or pregnancy related problems) and the year they took place

Condition	Year

Please list any medication that you are taking (or attach repeat prescription order form)

Name	Form (tablets / capsule / liquid / etc)	Dose	How many times a day?

Are you allergic to any medicines and if so which? Yes No

Do you have any other allergies and if so please give details Yes No

Information About You

What is your height?

What is your weight?

What is your first language?

Do you need an interpreter?

Yes No

Ethnic Group

White

British

Irish

Other

Black

Caribbean

African

Other

Asian

Indian

Pakistani

Chinese

Other

Mixed

White + Black Caribbean

White + Asian

White + Black African

Other

Have you **served in the Armed Forces**?

Yes No

Do you have any disabilities or special needs? (If yes, please give details) Yes No

Carers

Our practice is committed to supporting carers. Is there a child or young person in the family who helps to provide care or support to another family member? Approximately 10% of the current population are carers. www.durhamcarers.info

Do you have a carer? (if yes, please give details) Yes No See [NHS Choices](#)

Are you a carer? (if yes, then please give details) Yes No See [NHS Choices](#)

If you would like to give permission for someone else to help deal with your health needs including medication and results then please ask a receptionist for more details about how we can arrange this

Smoking

Do you smoke? Yes No

If yes; How many cigarettes per day or ounces / grams of tobacco per week?

How long have you smoked for?

If no; Have you ever smoked? Yes No

If you have smoked; How many years did you smoke for?

How many cigarettes per day or ounces / grams of tobacco per week did you smoke on average?

We always encourage smokers to give up smoking and can offer help and support with doing this – see [NHS Choices](#). If this is something that you would like more information about then please speak to one of our receptionists or phone 0800 011 3405.

Alcohol

1 drink = ½ pint of beer or 1 small glass of wine or 1 single spirit

For more information see [NHS Choices](#).

How much do you drink in an average week?

MEN: How often do you have EIGHT or more drinks on one occasion?

WOMEN: How often do you have SIX or more drinks on one occasion?

How often during the last year have you been unable to remember what happened the night before because you had been drinking?

How often during the last year have you failed to do what was normally expected of you because of drinking?

In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

Family History

Please state any serious illness, in particular cancer, heart disease, stroke, high blood pressure, diabetes or any inherited disease. Please state your relationship to the individual and in the case of cancer, the type of cancer.

Immunisations

For patients aged over 64 and over or those with a chronic disease (eg asthma or diabetes)

Have you ever had a **Flu vaccination**? Enter date or 'never'

Have you ever had a **Pneumonia vaccination**? Enter date or 'never'

Women

Have you ever had a cervical smear? Yes No

If yes then when was the date of your most recent cervical smear and the result?

Have you had a mammogram? Yes No

If yes then when was the date of your most recent mammogram and the result?

Advance Decisions (For information see [NHS Choices](#))

Do you have a living will or advance decision to refuse treatment? Yes No

Do you have a personal welfare lasting power of attorney? Yes No

Contacting You

I agree that I may be contacted from time to time, via email and/or SMS, with practice news or surveys, advice about my health and/or appointment reminders. Yes No

Consent to Share Information

PLEASE COMPLETE ALL SECTIONS (You are able to change your decision at any time)

Summary Care Record – My Emergency Care Summary

This will be used in emergency care. The record will contain essential information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had, to ensure those caring for you have enough information to treat you safely.

- YES;** I would like a Summary Care Record. Healthcare staff will ask your permission before they look at your record, except in certain circumstances for example if you are unconscious.
- NO;** I do not want a Summary Care Record.

Electronic Patient Record Sharing

Sharing Out

Do you consent to Barnard Castle Surgery allowing other health care services who are directly involved with your care and using a compatible computer system to see data held by the practice?

- YES:** I consent to share data with other compatible computer system users involved in my care.
- NO:** I do not consent to share data recorded at Barnard Castle Surgery with other system users involved in my care.

Sharing In

Do you consent to Barnard Castle Surgery viewing any data recorded at other health care services that may care for you?

- YES:** I consent to Barnard Castle Surgery viewing data held by other Health Care organisations.
- NO:** I do not consent to share data recorded at other organisations with Barnard Castle Surgery.

Signature

Signature

Date

Further information about Barnard Castle Surgery and the services we offer can be found on our website at www.barnardcastlesurgery.co.uk

- We have a patient participation group and you would be welcome to join this.
- Patients aged 75 and over will be given a 'Named GP'.
- Patients at increased risk of hospital admission will be offered a care co-ordinator
- If you are aged 40-74 without a pre-existing condition we would be pleased to offer you an NHS Health Check. This is your chance to get a free midlife MOT!– further details can be found on the [NHS Choices](#) website