NEW PATIENT HEALTH QUESTIONNAIRE

Please speak to a member of our team if you require this information in a format other than our standard print.

ALL ITEMS ASTERISKED * MUST BE COMPLETED

PLEASE WRITE CLEARLY, IN BLACK INK AND USE CAPITALS

***TITLE:**

○ **MR** ○ **MRS** ○ **MISS** ○ **MS** ○ **OTHER**

***GENDER:**

○ **MALE** ○ **FEMALE** ○ **OTHER**

***SURNAME:** **PREVIOUS SURNAME:** ***FIRST NAME(s):**

***DATE OF BIRTH:** ***FIRST LANGUAGE:**

PLEASE USE THIS FORMAT DD/MM/YYYY

WHAT IS YOUR ETHNIC GROUP?
CHOOSE ONE OPTION THAT BEST DESCRIBES YOUR ETHNIC GROUP OR BACKGROUND:

WHITE	**PLEASE TICK** √
1. ENGLISH / WELSH / SCOTTISH / NORTHERN IRISH / BRITISH	
2. IRISH	
3. GYPSY OR IRISH TRAVELLER	
4. ANY OTHER WHITE BACKGROUND (*PLEASE DESCRIBE*)	

MIXED / MULTIPLE ETHNIC GROUPS	
5. WHITE AND BLACK CARIBBEAN	
6. WHITE AND BLACK AFRICAN	
7. WHITE AND ASIAN	
8. ANY OTHER MIXED / MULTIPLE ETHNIC BACK GROUND (*PLEASE DESCRIBE*)	
ASIAN / ASIAN BRITISH	
9. INDIAN	
10. PAKISTANI	
11. BANGLADESHI	
12. CHINESE	
13. ANY OTHER ASIAN BACKGROUND (*PLEASE DESCRIBE*)	
BLACK / AFRICAN / CARIBBEAN / BLACK BRITISH	
14. AFRICAN	
15. CARIBBEAN	
16. ANY OTHER BLACK / AFRICAN / CARIBBEAN BACKGROUND (*PLEASE DESCRIBE*)	
OTHER ETHNIC GROUP	
17. ARAB	
18. ANY OTHER ETHNIC GROUP (*PLEASE DESCRIBE*)	

***ARE YOU NEW TO THE UK** ○ **YES** ○ **NO**

***DATE YOU ARRIVED IN UK**

PLEASE USE THIS FORMAT
DD/MM/YYYY

***DO YOU SPEAK ENGLISH** ○ **YES** ○ **NO**

***CAN YOU READ ENGLISH** ○ **YES** ○ **NO**

***DO YOU REQUIRE AN INTERPRETER** ○ **YES** ○ **NO**

HAVE YOU EVER SERVED IN THE BRITISH ARMED FORCES? ○ **YES** ○ **NO**

*HOME ADDRESS:

*POSTCODE:

HOME PHONE NUMBER:

MOBILE PHONE NUMBER:

WORK PHONE NUMBER:

EMAIL ADDRESS: (PLEASE WRITE CLEARLY)

Your next kin is your closest blood relative; i.e. mother, father, husband, wife, brother, sister, child.

NEXT OF KIN NAME:

RELATIONSHIP:

PHONE NUMBER:

FIRST NAMES AND SURNAME REQUIRED

NEXT OF KIN DATE OF BIRTH:

PLEASE USE THIS FORMAT DD/MM/YYYY

NEXT OF KIN HOME ADDRESS:

PLEASE INFORM THE SURGERY IN WRITING, IF YOU WOULD LIKE TO SHARE YOUR MEDICAL INFORMATION WITH YOUR NEXT OF KIN.

IF YOU DO NOT HAVE A NEXT OF KIN PLEASE PROVIDE EMERGENCY CONTACT DETAILS:

EMERGENCY CONTACT NAME:
FIRST AND SURNAME REQUIRED

RELATIONSHIP:

PHONE NUMBER:

I

EMERGENCY CONTACT ADDRESS:

WHAT IS YOUR CURRENT RELIGION, IF ANY:

CAN WE CONTACT YOU BY TEXT ○ **YES** ○ **NO**

CAN WE CONTACT YOU BY EMAIL ○ **YES** ○ **NO**

PLEASE NOTE THAT WE MAY SEND YOU INFORMATION OF A CONFIDENTIAL NATURE USING A SECURE NETWORK. IT IS THE PATIENT'S RESPONSIBILITY TO ENSURE THEIR EMAIL IS PROTECTED FROM MALWARE

THERE MAY BE OCCASIONS WHEN WE CORRESPOND WITH YOU BY LETTER.

WHAT IS YOUR PREFERRED METHOD OF COMMUNICATION?

PLEASE INFORM US IF YOU HAVE ANY ADDITIONAL INFORMATION OR COMMUNICATION NEEDS.

ARE YOU A CARER ○ **YES** ○ **NO**

ARE YOU A YOUNG CARER? ○ **YES** ○ **NO**

You are a young carer if you are aged 18 years and younger and look after someone in your family who has a disability, long term illness, or is affected by mental ill health or substance abuse.

Please can all carer's, including young carer's, complete the attached 'Carer's Identification Form' at the end of this questionnaire.

IF YES PLEASE GIVE DETAILS OF WHO YOU CARE FOR:

FULL NAME:

RELATIONSHIP:

DOES SOMEONE CARE FOR YOU? ○ **YES** ○ **NO**

IF YES PLEASE GIVE YOUR CARER'S DETAILS:

NAME:

RELATIONSHIP:

TELEPHONE NUMBER:

DO YOU HAVE ANY KNOWN ALLERGIES:

DO YOU HAVE ANY KNOWN LONG TERM ILLNESSES (CURRENT & PAST):
(I.E CANCER, DIABETES, HEART DISEASE, ASTHMA, COPD)

DOES YOUR FAMILY HAVE A HISTORY OF LONG TERM ILLNESS:

FAMILY MEMBER:	ILLNESS:

PLEASE USE THE BACK OF THIS FORM IF YOU NEED TO LIST ADDITIONAL INFORMATION.

PLEASE USE THE EQUIPMENT IN THE WAITING ROOM TO PROVIDE THE FOLLOWING INFORMATION:

HEIGHT (cm):	WEIGHT (kg):

BLOOD PRESSURE:

SYS	DIA	PUL

SMOKING STATUS:

- ○ **NEVER SMOKED**
- ○ **EX SMOKER**
- ○ **CURRENT SMOKER**

IF YOU SMOKE PLEASE TELL US HOW MANY CIGARETTES YOU SMOKE EACH DAY:

NUMBER OF UNITS OF ALCOHOL PER WEEK:
PLEASE USE THE CHART BELOW AS A GUIDE:

UNITS	2	2.5	2	1	9
					
	Pint of Regular Beer/Lager/Cider	Alcopop or can of Lager	Glass of Wine (175ml)	Single Measure of Spirits	Bottle of Wine

NUMBER OF HOURS OF EXERCISE PER WEEK:
PLEASE TICK THE BOX THAT APPLIES

I DO NO PHYSICAL EXERCISE ○

I EXERCISE LESS THAN ONE HOUR PER WEEK ○

I EXERCISE BETWEEN 1-3 HOURS PER WEEK ○

I EXERCISE OVER 3 HOURS PER WEEK ○

***IT IS THE PRACTICE POLICY TO SEND PRESCRIPTIONS ELECTRONICALLY TO THE PHARMACY OF YOUR CHOICE. PLEASE PROVIDE YOUR CHOSEN PHARMACY NAME AND LOCATION:**

***CHILD HEALTH REQUIRES DETAILS OF ALL IMMUNISATIONS FOR ANY CHILD UNDER THE AGE OF 16 YEARS THAT IS NEW TO THE UNITED KINGDOM. PLEASE PROVIDE OFFICIAL, WRITTEN DOCUMENTATION OF ALL IMMUNISATIONS FROM YOUR CARE PROVIDER (HOSPITAL/DOCTOR/HEALTH CLINIC). IT IS IMPORTANT THAT THIS INFORMATION IS PROVIDED IN ENGLISH.**

WE RECOMMEND THAT PATIENTS SIGN UP TO PATIENT ON LINE ACCESS. THIS PROVIDES YOU WITH THE FACILITY OF MAKING/CANCELLING APPOINTMENTS, ORDERING MEDICATION AND VIEWING YOUR MEDICAL INFORMATION. PLEASE COMPLETE THE ATTACHED REQUEST FORM TO USE THIS SERVICE. YOU WILL RECEIVE AN EMAIL OR LETTER WITH ACCESS DETAILS ONCE YOUR ACCOUNT HAS BEEN AUTHORISED.

PARENTS REGISTERING A CHILD AGED 11 TO 16 YEARS: PLEASE BE AWARE THAT YOU WILL NEED TO APPLY FOR PROXY ACCESS SHOULD YOU WISH TO CONTROL ACCESS TO YOUR CHILD'S RECORD AND ONLINE SERVICES. PLEASE ASK A MEMBER OF OUR RECEPTION TEAM FOR A PROXY ACCESS REQUEST FORM IF YOU REQUIRE THIS SERVICE.

PATIENTS WITH A SENSORY IMPAIRMENT OR LEARNING DISABILITY WILL HAVE THEIR RECORDS CODED SO THAT WE MAY BETTER COMMUNICATE WITH YOU. PLEASE BE AWARE THAT THIS INFORMATION IS SHARED WITH OTHER CARE PROVIDERS.

PATIENTS THAT WISH TO WITHDRAW THEIR CONSENT TO THEIR CHOSEN FORM OF COMMUNICATION, WILL NEED TO INFORM THE PRACTICE IN WRITING.

***SIGNATURE:**

PARENT/CARER/GUARDIAN

***DATE:**

PLEASE USE THIS FORMAT DD/MM/YYY

Christchurch Surgery
North Street
Downend
Bristol
BS16 5SG
0117 9709 500

Willow Surgery
Hill House Road
Downend
Bristol
BS16 5FJ
0117 9709 500

PATIENT ONLINE ACCESS REQUEST

PATIENT NAME	
DATE OF BIRTH	

I request online access to (please tick where applicable):-

APPOINTMENT BOOKING	
PRESCRIPTION ORDERING	
ACCESS TO DETAILED CARE RECORDS	*For access to your Detailed Care Records please ask a member of our Patient Assistant Team for the relevant Form*

Notice to the Patient:
Some of the information in your medical record written by our GP's and clinical staff may be highly technical and not easily understood. If you require further clarification, please contact the surgery for a clearer explanation.

It is your choice whether you wish to share your information with others however it is important to understand that it is your responsibility to keep the information safe and secure. Should you wish to provide others with access to your online facilities, you will need to complete a Proxy Access Form, a member of our Patient Assistant Team can provide you with this.

If you think you may be pressured into revealing details from your patient record to someone else against your will then it is best you do not register for access at this time. Please contact the surgery for an appointment with a GP if you feel you are being coerced into sharing your personal information.

For further information on how best to use our online facilities please use the following link: https://www.england.nhs.uk/wp-content/uploads/2016/11/pat-guid-getting-started-gp-online.pdf

I confirm that I have read the above statement and would like Downend Health Group to set up online patient access on my behalf.

Patient Signature ……..

Date ……..

INTERNAL USE

PHOTOGRAPHIC ID PROVIDED?	
PROOF OF ADDRESS PROVIDED?	
ONLINE ACCESS AUTHORISED?	
LOG IN & PASSWORD DETAILS EMAILED?	
Authorisation Date: Staff Name: Position:	

CARERS **IDENTIFICATION FORM**

YOUR DETAILS:

Name	
Date of Birth	
Address	
Post Code	
Telephone Number	
Are you related to the person cared for? Please state relationship	

DETAILS OF THE PERSON YOU LOOK AFTER:

Name	
Date of Birth	
Address (If different from above)	
Post Code	
Telephone Number (If different from above)	
Any other relevant information	

Your details will be passed to The Carers' Support Service. This organisation provides relevant information and advice, local support services, newsletters and a telephone linkline for carers. If you would prefer us not to, please tick the box below.

□ Please DO NOT pass my details to the Carers' Support Service.