OBSERVATORY MEDICAL PRACTICE

For surgery use only

Rec'd by……

Reg by……...

Somerville College New Patient Questionnaire

USUAL GP……

Welcome to the practice. Because there are inevitable delays, sometimes of several months, in the transfer of medical records, please answer the following brief questionnaire about your medical history. Please answer all questions unless otherwise indicated.

SURNAME ……. DATE OF BIRTH ……

FORENAMES ……. MALE / FEMALE ……

ADDRESS ……

……POSTCODE……

TELEPHONE: HOME…… WORK……..MOBILE …….

EMAIL ADDRESS ……..
Please note your email address may be shared with other NHS organisations

PLACE OF BIRTH……..

ETHNICITY & LANGUAGE As an NHS service provider we are also required to ask you about your ethnicity, therefore please tick ✓ the appropriate answer below:	
White ☐ British ☐ Any other white background, please specify:	**Black or Black British** ☐Caribbean ☐ African ☐ Any other black background, please specify:
Mixed ☐ White & Black Caribbean ☐ White & Black African ☐ White & Asian ☐ Any other mixed background, please specify:	**Asian or Asian British** ☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Any other Asian background, please specify:
Chinese or other ethnic group ☐ Chinese ☐ Any other, please specify:	☐ I don't wish to provide information on my ethnic group
First Language: If your first language is not English, do you require an interpreter?	

Next of kin

Name …… Telephone …….. Relationship …….

Address……..

March 2017

Medical history

Please list all significant present and past illnesses or medical problems.

Date started	Problem/disease/disability
OTHER…..	

Please list all current medication or prescribed appliances. If you are on medication, please make an appointment to discuss this with one of the doctors, a phone consultation may be suitable

Drug or medication	Dose – eg:1 tablet twice a day
OTHER…..	

If you're under the age of 25:

Have you been immunised against the following? (please tick)

Tetanus □ Meningitis C □ MMR1□ MMR2□

FAMILY HISTORY

It is particularly important to know about close relatives who have had coronary heart disease or strokes before the age of 60 and if they died prematurely because of this.

Relative	Problem	Age when diagnosed	Age when died

Have your parents, brothers or sisters ever had any of the following diseases?

Disease	Yes	No	Who	At what age?
High Blood Pressure				
Raised Cholesterol				
Angina				
Diabetes				
Glaucoma				
Breast Cancer				
Colon Cancer				

Please note here any other disease in the family you feel is significant:

HEALTH PROMOTION

The following questions will enable us to assist you with taking more control of your own health, please answer them as accurately as you can.

Height	_____ cms, or _____ft _____ ins
Weight	_____ kg, or _____ st _____ lbs
Blood Pressure (please use the machine in the waiting room) **if over 140 / 85 take 3 readings**	_____ / _____

Smoking	
Do you smoke? Yes / No	If yes, what, and how many per day?
If yes, would you like smoking cessation advice? Yes / No	
If no, are you an ex-smoker? Yes / No	**If yes, date quit:**

Alcohol – Please complete the following questions

Do you drink alcohol regularly? Yes / No

How many glasses of wine do you drink a week ?…….
How many pints of beer do you drink each week ?……
How many glasses of spirits do you drink each week? …….

	Scoring system					
Questions	**0**	**1**	**2**	**3**	**4**	**Your score**
How often do you have a drink that contains alcohol?	Never	Monthly or less	2 – 4 times per month	2 – 3 times per week	4+ times per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1 – 2	3 – 4	5 – 6	7 – 8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

A total score of 5+ indicates possible harmful drinking.

If you have scored 5+. Please complete the Alcohol users Disorders Identification Test overleaf.

Alcohol users Disorders identification Test (AUDIT)

Please complete the following questionnaire if you have scored 5 or over in the short questionnaire above.

	Scoring system					
Questions	**0**	**1**	**2**	**3**	**4**	**Your score**
How often do you have a drink that contains alcohol?	Never	Monthly or less	2 – 4 times per month	2 – 3 times per week	4+ times per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1 – 2	3 – 4	5 – 6	7 – 8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or someone else been injured as a result of your drinking?	No		Yes but not in the last year		Yes, during the last year	
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	No		Yes but not in the last year		Yes, during the last year	

WOMEN AGED 25-65 PLEASE COMPLETE THE FOLLOWING: **Cervical Smear** **Women who have been sexually active should have regular cervical smears. Women who have had a hysterectomy or who have never had a sexual partner do not need one.**	
Have you ever had a cervical smear test? Yes/No	If so, when was your last smear?
Result of your most recent cervical smear:	Normal / Abnormal
If your smear was done abroad, please supply us with a copy of the result	
Have you had a Hysterectomy? Yes/No (If Yes, please give us details in the Past Illnesses section)	
Are you currently on any form of birth control? **Yes / No** Please specify **If on the contraceptive pill please see a GP for the first prescription.**	

If you would like us to send your prescription to a local Pharmacy, please give us the name of your nominated Pharmacy.

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Carers

Are you a carer for an elderly or disabled relative, friend or neighbour? If so please give details.

Armed Forces

Have you ever served in the Armed Forces? Yes/No
If your answer is Yes, please tick one of the following

Army…….**Navy**……**Air Force**……

If you would like this form printed on coloured paper to make it clearer. Please ask at reception.

To help us communicate with you effectively. Please let us know if you have any special requirements.

Sharing your medical information – your healthcare, your choice

Your patient record is held securely and confidentially on an electronic system controlled by your GP Surgery.

If you need treatment in another NHS healthcare setting, such as an Emergency Department, Out-of-Hours GP or Minor Injury Unit, the professionals treating you can give you safer care if medical information from your GP Surgery is available to them.

This document explains the different ways your medical information can be shared with those professionals, if you choose to allow this.

Your health information can now be shared electronically through these systems:

1.	**The Summary Care Record:**	Used nationally across England
2.	**The Oxfordshire Care Summary** and the **Out-of-Hours GP records sharing system**	Used locally by healthcare professionals in Oxfordshire

In all these cases, your information will be viewed ***only by authorised healthcare professionals directly involved in your care***. You will be asked for your permission before the information is accessed, unless the health professional is unable to ask you and there is an important clinical reason for accessing it.

If you do not want your information shared, we will put an entry on your record which will prevent this. It is important to note that if you make this choice, the health professionals using these systems will not be able to view your health information in an emergency, even if you give them permission to do so at the time.

For more details of these systems, please see overleaf.

A parent or guardian can ask to opt out children aged under 16 but ultimately it is the GP's decision whether to do this, because their duty of care to the child has top priority. If you care for a child under 16 and feel that they are able to understand this decision, then you should make this information available to them and seek their view.

Please complete the form below and return it to your GP Surgery

It is important to complete and return this form, as your GP cannot make a decision for you. Without your instructions, we cannot guarantee that your wishes will be met, even if you have previously made this choice in another GP Surgery.

Patient details **(please write in CAPITAL LETTERS)**			
Title:		**Forenames**:	
Surname/Family name:			
Address:			
Phone number(s):		**Email:**	
Date of birth:		**NHS number (if known):**	
Signature:		**Date:**	

FOR PARENTS, GUARDIANS and ATTORNEYS ONLY – ***If the person identified above is not the patient, please also enter the signatory's name and relationship to the patient:***			
Full name:		**Status:**	
Signature:		**Date:**	

Your choices:	**I wish to share my information**	**I do <u>NOT</u> wish to share my information**
Summary Care Record (national NHS system) *Please tick one of these boxes:*		
Summary Care Record with Additional Information* (see next page) *Please tick one of these boxes:*		
Oxfordshire Care Summary and the Out-of-Hours GP records sharing system (local NHS system) *Please tick one of these boxes:*		