Do you have any special communication needs? ☐ Yes ☐ No

If yes: ☐ Sign Language ☐ Large Print ☐ Other

……

Castle Gardens Surgery New Patient Questionnaire

Today's Date:

Please complete in BLOCK CAPITALS and tick the boxes as appropriate.

Please complete a separate form for each family member to be registered.

THIS FORM MUST BE **COMPLETED** BEFORE WE CAN **COMPLETE YOUR REGISTRATION**

Mr / Mrs / Miss / Ms / Other:	**Surname:**	**First Name:**	**Previous Surnames:**
Date of Birth:		**Occupation:**	**Home Tel:**
Address and Postcode:			**Work Tel:**
			Mobile:

INFORMATION ABOUT YOU			
What is your height?		**What is your weight?**	
What is your first language?		**Do you need an interpreter?**	**YES/ NO**

Your Ethnic Origin: (select one)				
White	**British**	**Irish**	**Other**	**If "other" please specify:**
Black	**Caribbean**	**African**	**Other**	**If "other" please specify**
Asian	**Indian**	**Pakistani**	**Chinese**	**If "other" please specify**
	Other			
Mixed	**White + Black Caribbean**		**White + Black African**	**White + Asian**
	Other			**If "other" please specify**

Previous GP
Name and Address of Previous GP:

Proof of Identity and Address Provided

☐ Birth Certificate ☐ Driving Licence ☐ Passport ☐ Utility Bill

☐ Allowance Book ☐ Solicitor's Letter ☐ Offer of Tenancy

☐ Other, *please specify*……

Medical Information

Please list any serious illnesses/ operations/ disabilities (and for women any pregnancy related problems) and the year they took place:

Have you ever suffered from? (tick as appropriate)

Epilepsy	Yes/ No	Blindness/ Glaucoma	Yes/ No
High Blood Pressure	Yes/ No	Diabetes	Yes/ No
Heart Disease/ Stroke	Yes/ No	Asthma	Yes/ No
Cancer	Yes/ No	COPD	Yes/ No
Rheumatoid Arthritis	Yes/ No	Osteoporosis	Yes/ No
Anxiety	Yes/ No	Depression	Yes/ No
Bipolar Disorder	Yes/ No	Other mental health issues	Yes/ No

If yes, please state the year (s) when were you first diagnosed?

Are you receiving or have you received any treatment or therapy? (if yes please give details of your care and when you received it)

Please list any medicines being taken and the amount *, or attach a repeat medication slip.*

Are you registered disabled? (if yes, please give details) Yes/ No

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

What symptoms did you have?

Have you ever refused treatment/ screening of any kind and if so, what and when? Yes/ No

Carers

Do you have a carer? (if yes please give details) Yes/ No

Are you a carer? (if yes please give details) Yes/ No

Will

Do you hold a living will? Yes/ No

(A living will is documentation regarding your personal wishes in respect of medical intervention at the time of serious illness)

Women

Have you ever had a cervical smear? (if "yes" please state when, where and the result) Yes/ No

Please give details and when these issues arose:

Smoking	
Do you smoke?	Yes/ No
If "No" have you ever been a smoker	Yes/ No
If you do currently smoke, would you like help to give up smoking, if so please book an appointment with one of our Healthcare Assistants.	

Alcohol ***(One unit = 1 small glass of wine, a single measure of spirits, or 1/2 a pint of beer)***	
How often do you have drink containing alcohol?	Never Monthly or Less 2-4 times a month 2-3 times a week 4 or more times a week
How many units of alcohol do you drink on a typical day when you are drinking?	1 or 2 3 or 4 5 or 6 7 or 8 10 or more
How often have you had **SIX** or more units if female, or **EIGHT** or more units if male, on a single occasion in the last year?	Never Less than monthly Monthly Weekly Daily or almost daily

Family History

Please state any serious illness, in particular cancer, heart disease, stroke, high blood pressure, diabetes in a relative under the age of 60 years. Please state your relationship to the individual and in case of cancer, the type of cancer.

Next of Kin

Please give name, address, telephone number and relationship of next of kin:

For patients aged 65 and over or those with chronic disease (eg, asthma or diabetes):

Have you had flu vaccination? Enter date or "never": …….

Have you had pneumococcal vaccination? Enter date or "never" ……

For patients who are in possession of firearms/ shotguns:

Do you hold a firearms/ shotgun licence: YES/ NO. If answer yes please record expiry date:……

SIGNATURE **(You will be asked to sign this form when you visit the practice)**	**……..** **Date:**

Patient Participation Group

The Practice is committed to improving the services we provide to our patients.
To do this, it is vital that we hear from people about their experiences, views, and ideas for making services better.
By expressing your interest, you will be helping us to plan ways of involving patients that suit you.
It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice.
If you are interested in getting involved, please tick the box below and we will arrange for the Practice Patient Participation Group Application Form to be given to you at your initial consultation.

Yes, I am interested in becoming involved in the Practice Patient Participation Group (Please tick the "Yes" Box)			**Yes**
Patient Signature:		**Signature on behalf of Patient:**	

Do you wish to have a new patient check? **If "Yes" please book an appointment with our Healthcare Assistants**	**Yes/ No**

Your new patient check will include having your height, weight and blood pressure taken, and a specimen of urine for testing (it would be helpful if you would bring a specimen with you when coming to the Practice).
The Consultation will also establish relevant past medical and family history, including:
- ***Medical factors - illnesses, immunisations, allergies, hereditary factors, screening tests, current health***
- ***Social factors - employment, housing, family circumstances***
- ***Lifestyle factors - diet and exercise, smoking, alcohol and drug abuse.***

OPT-OUT FORM

Request for my clinical information to be withheld from the Summary Care Record
If you DO NOT want a Summary Care Record please fill out the form and hand it to your GP practice

A. Please complete in BLOCK CAPITALS

Title ..... Surname / Family name .....Forename(s) .....
Address .....
Postcode ..... Phone No ..... Date of birth .....
NHS Number (if known) ..... Signature .....

B. If you are filling out this form on behalf of another person or a child, their GP practice will consider this request.Please ensure you fill out their details in section A and your details in section B

Your name ..... Your signature.....
Relationship to patient ..... Date .....

What does it mean if I DO NOT have a Summary Care Record?

NHS healthcare staff caring for you may not be aware of your current medications, allergies you suffer from and any bad reactions to medicines you have had, in order to treat you safely in an emergency.
Your records will stay as they are now with information being shared by letter, email, fax or phone.
If you have any questions, or if you want to discuss your choices, please contact your GP practice

Thank you for completing this form

For more information about the services we offer, please refer to your new patient pack or see our website: www.castlegardenssurgery.co.uk