WELCOME TO HIGHFIELD SURGERY

To register with this practice, please complete this questionnaire as fully as possible. It can take some time for your previous medical records to reach us. The information you give in this questionnaire will help us to provide you with good medical care.

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| **PERSONAL DETAILS** |
| Title | Mr / Mrs / Miss / Ms  | Have you been registered here before? | Yes [ ]  No [ ]  |
| Surname |  | Previous Name |  | Male Female |
| Forename(s) |  | Address |  |
| Date of Birth |  |  |
| NHS number |  |
| Home Tel: |  | Postcode: |  |
| Mobile: |  | Email: |  |
| Work Tel: |  | Occupation: |  |
| Name of School (if aged 12-18 years): |  |
| Emergency Contact Name: |  | Relationship: |  | Tel: |  |
| Next of Kin: |  | Relationship: |  | Tel: |  |
| Status | Single Married Separated Divorced Widowed Cohabiting |

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| **HEALTH DETAILS** |
| Please use the automatic equipment in the waiting room to record you blood pressure. Take the printed result to the Reception. (Adults only – BP not required for children) |
| Blood pressure  | / | Height |  | Weight |  |
| Do you smoke? |  Yes [ ]  No [ ]  | How many a day? |  |
| If yes, are you interested in giving up smoking? Yes No |  Yes [ ]  No [ ]  |
| If not a smoker, have you ever smoked? Yes No |  Yes [ ]  No [ ]  |
| If YES, when did you START? |  | When did you STOP? |  |
| How many per day?  | Cigarettes: Cigars: Pipe: |
| **Alcohol** – Alcohol use can affect your health and interfere with certain medications and treatments. Your answers will remain confidential so please be honest. Use the guide below to decide how many **UNITS** you drink a week. |
|  | Do you drink any alcohol? | Yes [ ]  No [ ]  |
| How many **units** / week? |  |
| **Drugs** |
| Do you have a drug addiction? | Yes [ ]  No [ ]  |
| **Exercise** – Do you take exercise? |  Yes [ ]  No [ ]  |
| On average, how many sessions of moderate or vigorous activity of twenty minutes or more duration do you usually do each week? |  sessions |

New Patient Questionnaire – 2

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| **MEDICAL HISTORY**Do you have, or have you had, any serious health problems (including operations) or long-term conditions? |
|  | **✓** | **Details** | **Date** (if known) |
| Asthma |  |  |  |
| Cancer |  |  |  |
| COPD |  |  |  |
| Chronic kidney disease |  |  |  |
| Diabetes |  |  |  |
| Epilepsy |  |  |  |
| Heart attack/disease |  |  |  |
| High blood pressure |  |  |  |
| High cholesterol |  |  |  |
| Osteoporosis |  |  |  |
| Stroke |  |  |  |
| Mental health problems |  |  |  |
| Underactive thyroid |  |  |  |
| Circulation problems |  |  |  |
| Other serious illness |  |  |  |
| Any operations |  |  |  |
| Any known allergies | Yes [ ]  No [ ]  If yes, please list. |
| Allergic to:  |  | Type of reaction: |  |
| Allergic to:  |  | Type of reaction: |  |

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| **REPEAT MEDICATION** |
| Are you on any medicines at present?  | Yes [ ]  No [ ]  |
| If you are on regular medication, please provide a recent printout (less than two months old) of your medication to Reception and we will arrange for the items to be set up on our clinical system.If you do not have a printout, please ask for a doctor’s appointment to discuss this.Do you take any other over-the-counter medication? If so please list: |

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| **ELECTRONIC PRESCRIPTION SERVICE (EPS)**  |
| The Electronic Prescription Service (EPS) is an NHS service. You will not have to visit the GP practice to pick up your paper prescriptions. Instead, your GP will send it electronically to your nominated Pharmacy. (An information sheet is included in your new patient pack with full details.) Please indicate your preference below: |
| I would like my repeat prescriptions sent electronically to: |  PharmacyBranch |
| I would prefer to collect my repeat prescriptions from the surgery [ ]  |

New Patient Questionnaire – 3

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| **FAMILY MEDICAL HISTORY**Have any of your immediate relatives (brothers/sisters/parents) had any of the following: |
|  | **✓** | **Details** | **Relationship** | **Date** (if known) |
| Heart attack or angina before age 60 |  |  |  |  |
| Heart attack or angina over age 60 |  |  |  |  |
| Asthma |  |  |  |  |
| Diabetes |  |  |  |  |
| Stroke |  |  |  |  |
| Cancer |  |  |  |  |
| Any inherited diseases |  |  |  |  |

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| **FEMALES ONLY** |
| Date of last cervical smear? |  | Are you pregnant? | Yes [ ]  No [ ]  |
| Have you had a hysterectomy? |  | Yes [ ]  No [ ]  |
| **Contraception** – what is your current method of family planning? |
| None |  | Coil |  | Injection |  |
| Contraceptive Pill |  | Sterilisation |  | Implant |  |
| Condom |  | Partner had vasectomy |  | Hysterectomy |  |

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| **CARERS**  |
| Do you look after an elderly or sick relative or friend? | Yes [ ]  No [ ]  |
| If YES, please indicate relationship: |  |
| Would you like to be put in touch with the Carers Bucks who can offer practical help and support? | Yes [ ]  No [ ]  |

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| **Ethnicity –** How would you describe your ethnicity?  |
| **White** | British | Irish | Other white |  |  |
| **Asian** | Asian British | Bangladeshi | Indian | Pakistani | Other Asian |
| **Black** | Black British | African | Caribbean | Oher black |  |
| **Mixed** | Asian & White | Asian & Black | Asian & Caribbean | White African | White Caribbean |
| **Other** | Chinese | Japanese | Middle Eastern | Other (please state) |  |
| Country of Birth: |  |
| Do you speak English? | Yes [ ]  No [ ]  | First Language (if not English): |  |

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|  **Appointments** – please book the following appointments if applicable |
| If you have asthma / COPD | Appointment with Respiratory Nurse  |
| If you have diabetes | Appointment with Diabetic Nurse |
| If you have heart disease | Appointment with Cardiac Nurse |
| If you want to quit smoking | Appointment with Nurse or Advice Leaflet |

**DATA SHARING**

Communication within the NHS is important to ensure that those who are caring for you have enough information to treat you safely. Traditionally health professionals exchanged medical information through letters, but in the modern age of computers, electronic exchange of information has become increasingly commonplace.

Highfield Surgery takes responsibility for your confidential medical information very seriously. This form offers you the opportunity to express your wishes as to whether or not you would like your medical record to be shared. In addition you can consent to receiving reminder text messages and if you would like to access our online services.

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| **PERSONAL DETAILS**  |
| Surname: |  | First Name |  | Date of Birth |  |

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| **SMS TEXT MESSAGING**  |
| Would you like to receive text message appointment reminders and other notices from Highfield Surgery? | Yes [ ]  No [ ]  |
| I consent to receiving appointment confirmations, reminders and other notices via text messages and will update the Surgery of any changes to my mobile number.  |
| Signature |  | Date |  |

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| **SUMMARY CARE RECORD (SCR)**  |
| The NHS in England has introduced the Summary Care Record, which will be used in emergency care. The record will only contain 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.Your Summary Care Record will be available to authorised healthcare staff providing your care anywhere in England, but they will ask your permission before they look at it, if possible. This means that if you have an accident or become ill, healthcare staff treating you will have immediate access to important information about your health.As a patient you have a choice. Please indicate your preference below:For further information visit the website [**www.nhscarerecords.nhs.uk**](http://www.nhscarerecords.nhs.uk)**,** or telephone the dedicated NHS Summary Care Record Information Line on 0300 123 3020.  |
| Do you wish to have a Summary Care Record? |  Yes [ ]  No [ ]  |
| Signature |  | Date |  |