The Village Surgeries Group - New Patient Questionnaire

Welcome to The Village Surgeries Group.

To register with this Practice, please complete this questionnaire as fully as possible. The questions have been designed to help your new GP get to know you and your medical history, It may take some time for your previous records to reach us. This is in strict confidence and will not be passed onto anyone without your consent.

Please complete and return ALL 4 pages and don't forget to sign and date the last page.

Personal Details

Title	Mrs/Miss/Ms/Mr	Have you been registered here before?		Yes ☐	No ☐
Surname		Previous Name		Male ☐	Female ☐
Forname(s)		Address			
Date of Birth					
NHS Number					
Home Tel. No.		Postcode			
Mobile Tel. No.		Email			
Work Tel. No.		Occupation			
Next of kin		Relationship			
Contact No		Address			
Status	Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Cohabiting ☐				

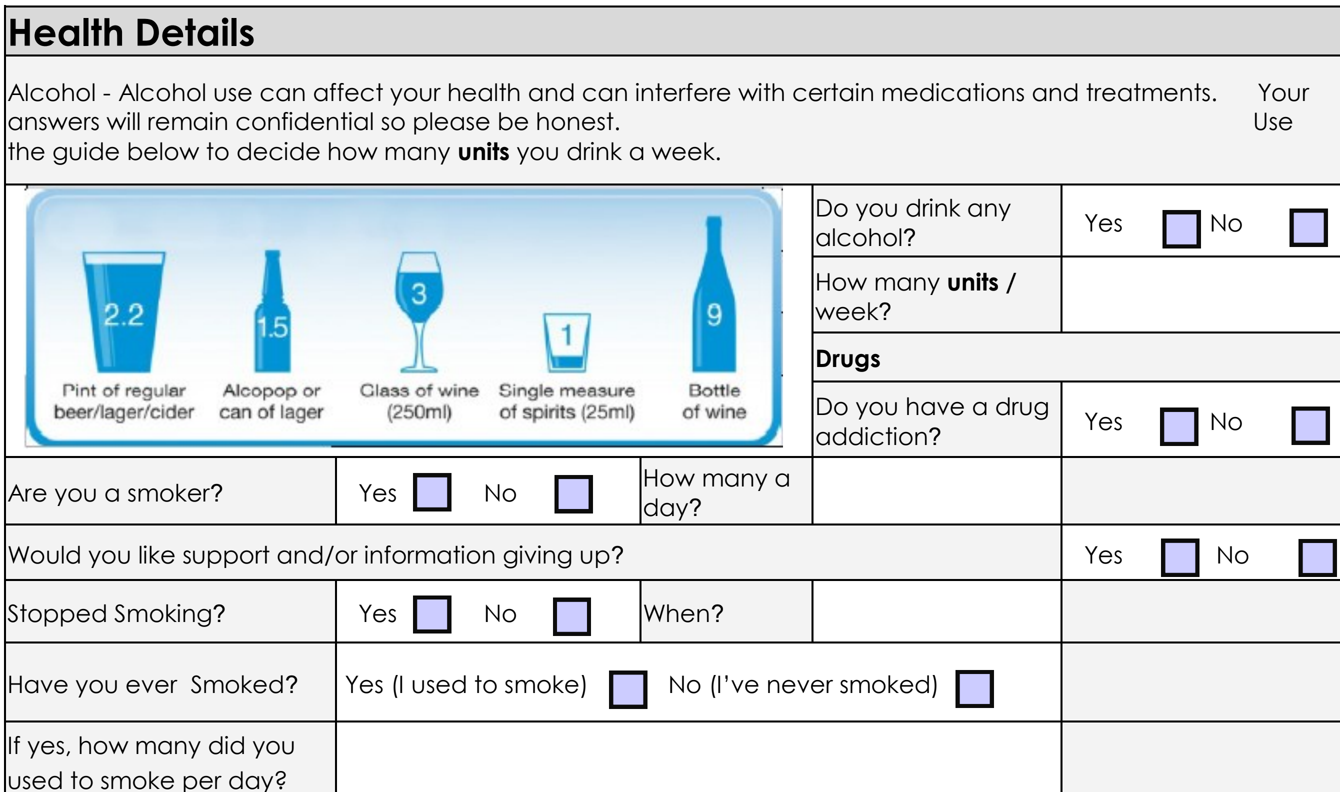
Ethnicity - How would you describe your ethnicity?

Please advise us of your First Language	English ☐	Other *(please state)*	

Health Details

Alcohol - Alcohol use can affect your health and can interfere with certain medications and treatments. Your answers will remain confidential so please be honest. the guide below to decide how many **units** you drink a week.

Your Use



Do you drink any alcohol?	Yes ☐	No ☐	
How many **units** / week?			
Drugs			
Do you have a drug addiction?	Yes ☐	No ☐	

Are you a smoker?	Yes ☐ No ☐	How many a day?		
Would you like support and/or information giving up?				Yes ☐ No ☐
Stopped Smoking?	Yes ☐ No ☐	When?		
Have you ever Smoked?	Yes (I used to smoke) ☐	No (I've never smoked) ☐		
If yes, how many did you used to smoke per day?				

Medical History - Do you have or have you had, any serious health problems (including operations)/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 illnesses	☐		
Any operations	☐		

Any know allergies	Yes ☐ No ☐	Allergic to	
Details of the reaction			

Repeat prescription

Are you on any repeated medication?	Yes ☐ No ☐	
If "Yes", do you have a repeat prescription slip from your previous GP?	Yes ☐ No ☐	

If "Yes", please hand it in at Reception. If "No" then list below any current medication you are taking and make sure you show Reception all your medication in its orignal packaging and labelling. We may need to contact your previous GP surgery to confirm your medication.

Name of drug	Frequency *(how often taking it)*	Reason for using drug

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 after age 60	☐			
Asthma	☐			
Diabetes	☐			
Stroke	☐			
Cancer	☐			
Any inherited diseases	☐			

Hospital Care *(The doctor may discuss with you the possibility of transferring your care to a local hospital)*

Are you currently under hospital care?	Yes ☐ No ☐	If "Yes", then complete the details below
Hospital Name	Name of Consultant	Nature of problem

Do you consider yourself to have a disability?	Yes ☐ No ☐			
Details of impairment	Physical impairment ☐	Learning disability/difficulty ☐		
	Sensory impairment ☐	Mental health condition ☐		
	Other *(please state)* ☐			

Are you a carer?	Yes ☐ No ☐	Is someone a carer for you?	Yes ☐ No ☐

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	☐

Children Only

Please provide details of all vaccinations			Date				Date
Diptheria/Tetanus/Whooping Cough/Polio	1	☐		Meningitis C	1	☐	
	2	☐			2	☐	
	3	☐			3	☐	
Pneumococcal	1	☐		Hib	1	☐	
	2	☐			2	☐	
	3	☐			3	☐	
Measles/Mumps/Rubella (MMR)	1	☐		Hib booster		☐	
	2	☐		Men C booster		☐	
Preschool Diptheria/Tetanus/Whooping Cough/Polio		☐		HPV	1	☐	
Rubella		☐			2	☐	
BCG		☐			3	☐	
Teenage booster Diptheria/Tetanus/Polio		☐		Other:		☐	
Other:		☐		Other:		☐	

Under the NHS Accessible Information Standard we are required to ensure that we make every effort to understand where our patients may have specific communication needs so we can help them appropriately.

Accessible Information Standard

Do you have any medical condition that may impair your communication?	Yes ☐ No ☐	
This may be due to a sight or hearing impairment, a learning disability, aphasia, autism or a mental health condition which affects your ability to communicate.		
If yes, what specific communication needs do you have?		

Thank you for completing this questionnaire. Please sign and date below, and arrange your new patient consultation . Please bring a urine sample with you to the appointment.

Signature ____ Date _______________

Office Use Only

Proof of identity	Passport ☐	Identity card ☐	Photo Driving Licence ☐	Other ☐
Proof of address	Utility Bill ☐	Bank statement ☐	Tenancy agreement ☐	Other ☐
Seen by Reception	Yes ☐ No ☐	Passport/Driving Licence No.		
Name of staff member				
Signature of staff member			Date	