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, as it may take some time for your previous records to reach us. Please complete and return ALL pages and don't forget to sign and date the last page.

Have you been registered here before?	Yes ☐ No ☐

Personal Details			
Title	Mr / Mrs / Miss / Ms / Other	Date of Birth	
First Names		Surname	
NHS Number *(if known)*		Previous Surname(s) *(if applicable)*	
What is your Gender?	Male ☐ Female ☐ Other ☐ _____		

Contact Details			
Home Address			
Home Telephone		Mobile Telephone	
Work Telephone		Email	
Preferred method of contact?	Phone (Home) ☐ Phone (Mobile) ☐ Email ☐ Text ☐		
Please note: We may use a combination of text, email, telephone, or post to contact you in relation to providing your healthcare.			

Information about you				
What is your height?		What is your weight?		
What is your first language?	English ☐	Other ☐ *(Please state)* _____	*Do you require an interpreter?*	Yes ☐ No ☐

Allergies	
Any know allergies?	Yes ☐ No ☐ *If yes, please give details* _____

Repeat Medication		
Are you on any repeat medication?	Yes ☐ No ☐	*If "Yes", to ensure a smooth transition to our practice, it would be beneficial if you could obtain a supply of your regular medications from your current GP.*
If you are on repeat medication, do you have a slip from your previous GP?	Yes ☐ No ☐	• *If "Yes", please attach to this form.* • *If "No" then list below any current medication you are taking.*

Name of drug	Dosage	Frequency	Reason for using drug

Electronic Prescribing Service

The Electronic Prescribing Service (EPS) is a free and easy secure service, that allows us to send your prescriptions electronically to your chosen pharmacy in England.

If you would like to use this service, please choose from one of the following local pharmacies, or specify a pharmacy.
Tattenhall Pharmacy ☐ Farndon Pharmacy ☐ Waverton Pharmacy ☐ Other ☐ _____

Unfortunately, prescriptions can't be sent electronically to pharmacies located in Wales. If you live in Wales, please speak to one of the receptionists to discuss your options.

Smoking

Do you smoke?	Yes ☐ No ☐ *If yes, how many per day?* _____ a day		
How many years have you smoked for?	_____ years	What do you smoke?	Cigarettes ☐ Cigars ☐ Pipes ☐
Are you a user of e-cigarettes?	Yes ☐ No ☐ *If yes, how many mg per day?* _____ mg		
Have you ever smoked?	Yes (I used to smoke) ☐ No (I have never smoked) ☐	*If yes, how many did you used to smoke?* _____ a day *and for how many years?* _____ years	
Would you like support and/or information giving up?	Yes ☐ No ☐		

Alcohol Intake

Alcohol - Alcohol use can affect your health and can interfere with certain medications and treatments.

UNIT GUIDE

1 unit is typically:

Half-pint of regular beer, lager or cider; 1 small glass of low ABV wine (9%); 1 single measure of spirits (25ml)

The following drinks have more than one unit:

A pint of regular beer, lager or cider, a pint of strong /premium beer, lager or cider, 440ml regular can cider/lager, 440ml "super" lager, 250ml glass of wine (12%)

AUDIT-C Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 – 2 units	3 – 4 units	5 – 6 or units	7 – 9 units	10 + units	
How often do you have 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					Total:	

Medical History

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

Have you ever suffered from? *(tick as appropriate)*			
Asthma	Yes ☐ No ☐	Hay Fever	Yes ☐ No ☐
Blindness / Glaucoma	Yes ☐ No ☐	Heart attack	Yes ☐ No ☐
Cancer	Yes ☐ No ☐	High blood pressure	Yes ☐ No ☐
Chronic Heart Disease	Yes ☐ No ☐	High cholesterol	Yes ☐ No ☐
Chronic Kidney Disease	Yes ☐ No ☐	Osteoporosis	Yes ☐ No ☐
Chronic Obstructive Pulmonary Disease (COPD)	Yes ☐ No ☐	Stroke	Yes ☐ No ☐
Diabetes	Yes ☐ No ☐	Mental health problems	Yes ☐ No ☐
Eczema	Yes ☐ No ☐	Underactive/Overactive thyroid	Yes ☐ No ☐
Epilepsy	Yes ☐ No ☐	Other serious illnesses	Yes ☐ No ☐

Are you registered disabled?	
Do you consider yourself to have a disability?	Yes ☐ No ☐
If yes, please give details:	

Carer details	
Are you a carer?	Yes ☐ No ☐ *If yes, who for?* _____
Are you a carer for someone with Dementia?	Yes ☐ No ☐
Do you depend on someone for day-to-day care?	Yes ☐ No ☐ *If YES please give name, relationship to that person. Are they also a patient of The Village Surgeries Group?* _____

Hospital Care		
Are you currently under the care of a hospital?	Yes ☐ No ☐ *If yes, please complete the details below.*	
Hospital Name	Name of Consultant	Nature of problem
Please note: If you are under the care of a hospital that is out of the local area the doctor may discuss with you the possibility of transferring your care.		

Females Only	
Have you ever had a cervical smear?	Yes ☐ No ☐ *If yes, please state the last date* ____ / ____ / ____
Have you had a hysterectomy?	Yes ☐ No ☐ *If yes, please state the date of the procedure* ____ / ____ / ____
Contraception – what is your current method of family planning?	
If you are currently pregnant, please ensure you notify one of the receptionists.	

Family History

Please state any serious illness, in particular cancer, heart disease, stroke, high blood pressure, diabetes or any inherited disease. Please state your relationship to the individual and in the case of cancer, the type of cancer.)

		Relationship to you	Details	Date (if known)
Asthma	☐			
Cancer	☐			
Diabetes	☐			
Heart attack or angina before age 60	☐			
Heart attack or angina after age 60	☐			
Stroke	☐			
Other inherited diseases	☐			

Next of Kin					
Next of Kin		Relationship		Contact Number	
Address					

Accessible Information Standard

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. 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.

Do you have any medical condition that may impair your communication?	Yes ☐ No ☐
If yes, what specific communication needs do you have?	

Summary Care Record	
Are you happy for a full/extended record to be shared with out of hours/emergency services to assist with your personal care?	Yes ☐ No ☐

National Data Opt Out

Are you happy for your confidential patient information to be used for planning and improving health services or for healthcare research? (Type 1 opt out). IF NOT you need to register your dissent by visiting https://www.nhs.uk/your-nhs-data-matters/ or call NHS Digital Contact Centre 0300 303 5678 (Mon to Fri 9 am to 5 pm (excluding Bank Holidays))

Thank you for completing this questionnaire. Please sign and date below.	
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:	____ / ____ / ____