



New Patient Questionnaire (Adult)

For Office Use Only

Photo ID seen? YES / NO
 Patient informed of registered GP? YES / NO
 Name of Registered GP: _____
 Consent signed? YES / NO
 Online access completed: YES / NO

Welcome to Brockwell Medical. Please complete this questionnaire as fully as possible. It gives us essential information about your health whilst we are awaiting your medical records.

Date:
 Surname:
 Forename:
 Name known as:
 Date of birth:
 Marital status: Single / Married / Separated / Divorced / Widowed
 Other (please state)

Address:

 Postcode:

Home telephone number:
 Work telephone number:
 Mobile telephone number:
 (Please tick preferred contact number)

Preferred site for appointments (please circle)	Cramlington	Seaton Delaval	Seaton Sluice
Nominated pharmacy for collecting electronic prescriptions:			

If born outside of the UK, please states the date you first entered the UK?:

Have you ever served in the armed forces? YES / NO
 If yes, please state: Date you enlisted Date of discharge

Next of Kin

Should we need to contact you urgently, or in the event of an emergency, we would be grateful if you could provide us with the following details:

Next of Kin: Mr / Mrs / Ms / Other (please state)

Name:
 Relationship:
 Address:

 Postcode:
 Telephone number (s): Home:
 Mobile:

Important information about repeat medication.

If you are taking regular prescribed medication, please provide us with a copy of your latest repeat medication list. This can be a recent prescription or a medication print-out from your previous GP. Please note: If repeat medication information is not provided, this may delay your first request for medication.

Have you attached / enclosed a printed copy of your repeat medication? YES / NO

Ethnicity – What is your ethnic origin? (Please tick one box)

- | | | | |
|--|--------------------------|---|--------------------------|
| White British | <input type="checkbox"/> | Indian | <input type="checkbox"/> |
| Other white ethnic group | <input type="checkbox"/> | Pakistani | <input type="checkbox"/> |
| Black African | <input type="checkbox"/> | Other Asian ethnic group | <input type="checkbox"/> |
| Black British | <input type="checkbox"/> | Other ethnic group (please Specify) | <input type="checkbox"/> |
| Black Caribbean / West Indies / Guyana | <input type="checkbox"/> | | |

Main spoken language:
Do you need an interpreter: YES / NO

Smoking

I am a smoker
(I smoke per day)

I am an ex-smoker
(Date stopped)

I have never smoked

Allergies

Are you allergic to anything (including medicines)? YES / NO

If yes, what are they:
.....
.....
.....

If you currently smoke and are interested in quitting, Stop Smoking Services can support you. Contact them on 01670 813135.

Carer details

If over 18 years, do you have a carer? YES / NO

If yes, please state your carers name and relationship:

Are you a carer (eg. Do you look after someone with physical / mental health problems)? YES / NO

If yes, please state who you care for (and relationship):

Do you have any problems with your hearing or speech, which would prevent you from having a telephone consultation with the doctor? YES / NO

If yes, please state the nature of the problem:

Do you have any problems with reading or writing? YES / NO

If yes, please state the nature of the problem:

Alcohol – Please circle the answer which best applies to you. If you score 3 or more, this might indicate hazardous or harmful drinking and we suggest filling in the more detailed AUDIT alcohol questionnaire below.

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often do you have 8 (men) / 6 (woman) or more units on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only answer the following questions if your answer above is monthly or less						
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	
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	
Has a relative / friend / doctor / health worker been concerned about your drinking or advised you to cut down?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Total Score						

Guide to units: A pint of regular beer / lager / cider 2 units 175ml glass of wine 2 units
 Single measure of spirit 1 unit Bottle of wine 9 units
 Bottle of alcopop, or can of lager 1.5 units

Alcohol Users Disorders Identification Test (AUDIT) – only to be filled in by people scoring 3 or more on the alcohol survey above.

Please circle the answer which best applies to you.

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink that contains alcohol?	Never	Monthly or less	2-4 times per month	2-3 time 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 of 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 of 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 of 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 of 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 of 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 of 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	
Total Score						

Scoring:

0 – 7 = sensible drinking
 8 – 15 = hazardous drinking
 16 – 19 = harmful drinking
 20+ = possible dependence

If you score 8 or more, we would advise you to discuss the matter at your new patient check or make a separate appointment with a doctor or nurse.

Patient Consent

This form will be scanned into your electronic patient record. This information will be used to help the practice provide you with complete and appropriate medical care. If you leave the practice, this information will be transferred with your medical record to the new practice.

Please sign below to give your consent. If you do not sign to consent, a member of the practice will contact you to discuss your options.

Signature of Patient:

Print:

Date:

The practice uses SMS messaging to send patient appointment reminders and other appropriate clinical information. If you have provided us with a mobile number and agree to the practice sending you this information via SMS please sign below.

Signature of Patient:

Print:

Date:

Patient Access – Patient Guidelines

Patient Access gives you online access to Patient Services via a secure website. Currently the services include:

- Booking telephone appointments
- Ordering repeat prescriptions
- Medical record viewer (summary of your care record).

To register for this service, you must complete the attached application form and return with your registration pack to the Reception Team.

For security purposes, you must provide photo ID to the Reception Team when you **collect** your username and password which may be up to 22 days after you hand the form in.

If you would like access to another patients records (i.e. an elderly parent, child or patient with a disability), please contact Paula Smith to discuss this on 01670 502337.

Please complete this form if you would like to register for online services.

Surname			
First name			
Date of birth			
Address			
Postcode			
Email address			
Telephone number		Mobile number	
I am registered at: (please tick)	Brockwell	Lintonville	Wellway

I wish to have access to the following online services (tick all that apply):

1. Booking appointments	<input type="checkbox"/>
2. Requesting repeat prescriptions	<input type="checkbox"/>
3. Accessing my medical record	<input type="checkbox"/>

Application for online access to my medical record

I wish to access my medical record online and understand and agree with each statement (please tick).

1. I have read and understood the information on the reverse of this form	<input type="checkbox"/>
2. I will be responsible for the security of the information that I see or download	<input type="checkbox"/>
3. If I choose to share my information with anyone else, this is at my own risk	<input type="checkbox"/>
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	<input type="checkbox"/>
5. If I see information in my record that it not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible	<input type="checkbox"/>

Signature		Date	
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Identity verified through (tick all that apply)	Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/> Photo ID <input type="checkbox"/> Proof of residence <input type="checkbox"/>	Name of verifier	Date
Name of person who authorised (if applicable)			Date

Please read the information overleaf before you sign

Important Information – Please read before returning this form

If you wish to, you can now use the internet to book telephone appointments with a GP, request repeat prescriptions for any medications you take regularly and look at your medical record online. You can also still use the telephone or call in to the surgery for any of these services as well. It's your choice.

It will be your responsibility to keep your login details and password safe and secure. If you know or suspect that your record has been accessed by someone that you have not agreed should see it, then you should change your password immediately.

If you can't do this for some reason, we recommend that you contact the practice so that they can remove online access until you are able to reset your password.

If you print out any information from your record, it is also your responsibility to keep this secure. If you are at all worried about keeping printed copies safe, we recommend that you do not make copies at all.

Before you apply for online access to your record, there are some other things to consider.

Although the chances of any of these things happening are very small, you will be asked that you have read and understood the following before you are given login details.

Forgotten history

There may be something you have forgotten about in your record that you might find upsetting.

Abnormal results or bad news

If your GP has given you access to test results, you may see something that you find upsetting. This may occur before you have spoken to your doctor or while the surgery is closed and you cannot contact them.

Choosing to share your information with someone

It's up to you whether or not you share your information with others – perhaps family members or carers. It's your choice, but also your responsibility to keep the information safe and secure.

Coercion

If you think you may be pressured into revealing details from your patient record to someone else against your will, it is best that you do not register for access at this time.

Misunderstood information

Your medical record is designed to be used by clinical professionals to ensure that you receive the best possible care. Some of the information within your medical record may be highly technical, written by specialists and not easily understood. If you require further clarification, please contact the surgery for a clearer explanation.

Information about someone else

If you spot something in the record that is not about you or notice any other errors, please log out of the system immediately and contact the practice as soon as possible.

More information

For more information about keeping your healthcare records safe and secure please visit our website: www.valensmedical.co.uk

Summary Care Records

Wellway Medical has signed up to Summary Care Records. All patients in the Practice will have a Summary Care Record unless they opt out. If you would like any further information regarding Summary Care Records, please contact Reception. Opt-out forms are also available from Reception.

Care.data

Under the Health and Social Care Act 2012 the Health and Social Care Information Centre (HSCIC) on behalf of NHS England will be able to extract personal and identifiable information about all patients in England.

What you need to do:

If you are happy for NHS England to direct the HSCIC to extract, store and manage / use your personal information then you need do **nothing** as the information will be automatically taken from our clinical system.

If you don't wish your information to be extracted, then you **MUST** tick the box below and we will then block the uploading of your identifiable and personal information to the HSCIC.

I do not agree to the uploading of my identifiable and personal information to the HSCIC.

If you are happy for your information to be extracted and used by the HSCIC for anonymised reports but **NOT** shared by the HSCIC with other agencies or companies in identifiable format, please tick the box below.

I do not agree to the sharing of my identifiable and personal information by the HSCIC with other agencies or companies.

Print name:

DofB:

Signed:

Date: