

FOR OFFICE USE ONLY:

Date registration received:

Checked by:

Signed? ☐On repeat meds? ☐

Barcellos Family Practice: New Patient Questionnaire

Welcome to the Barcellos Family Practice. To accurately register you at the surgery please fully complete this questionnaire in full. Please note your registration cannot be accepted until the forms are completed in full. Thank You.

Personal Details:

Title		Surname	
Forename		Middle Name(s)	
Previous Surnames (if applicable)		NHS Number	
Date of Birth		Marital Status	
Gender	Female <input type="checkbox"/> Unable to answer <input type="checkbox"/>	Male <input type="checkbox"/> Prefer not to say <input type="checkbox"/>	Non-Binary <input type="checkbox"/>
Is your gender the same as the sex you were assigned at birth?	Yes <input type="checkbox"/> Unable to answer <input type="checkbox"/>	No <input type="checkbox"/>	Prefer not to say <input type="checkbox"/>
House/Flat Number			
Street			
Town			
County			
Postcode			
Key Safe Number?			
First line of previous address (incl Postcode)			
Home Telephone		Mobile Telephone	
Email Address			
Next of Kin			
Relationship to you			
Next of Kin Telephone Number			

We need to have your consent to begin communicating with you by text or email.

Please confirm your consent by ticking to accept the options below:

☐ I consent to the practice contacting me by text message or email for the purposes of health promotion, practice news and for appointment reminders.

☐ I acknowledge that appointment reminders by text are an additional service and that they may not be sent on all occasions but that the responsibility for attending appointments or cancelling them still rests with me.

<input type="checkbox"/> Text messages are generated using a secure facility, but I understand that they are transmitted over a public network onto a personal telephone and as such may not be secure.			
<input type="checkbox"/> I understand I can cancel the text message facility at any time.			
Name and address of previous GP			
Country of Birth		Date entered the UK (if not UK born)	
Ethnicity	British or mixed British	<input type="checkbox"/>	Irish <input type="checkbox"/>
	African	<input type="checkbox"/>	Caribbean <input type="checkbox"/>
	Indian	<input type="checkbox"/>	Pakistani <input type="checkbox"/>
	Bangladeshi	<input type="checkbox"/>	Chinese <input type="checkbox"/>
	Other (please state)	<input type="checkbox"/>	
Religion	C of E <input type="checkbox"/>	Catholic <input type="checkbox"/>	Other Christian <input type="checkbox"/>
	Buddhist <input type="checkbox"/>	Hindu <input type="checkbox"/>	Muslim <input type="checkbox"/>
	Sikh <input type="checkbox"/>	Jewish <input type="checkbox"/>	Jehovah's Witness <input type="checkbox"/>
	No religion <input type="checkbox"/>	Other: <input type="checkbox"/>	
Employment	Employed <input type="checkbox"/>	Self Employed <input type="checkbox"/>	Student <input type="checkbox"/>
	Unemployed <input type="checkbox"/>	Homeless <input type="checkbox"/>	Housebound <input type="checkbox"/>
Overseas Visitor?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you hold an EHIC card (European Health Insurance Card)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you ever served in the armed forces?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Family Member has <input type="checkbox"/> served	

Communications:

Main spoken language	
Interpreter or special communication needs?	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please specify detail:
Are you an unpaid carer? If so, please provide details below:	
I care for (name)	
Relationship to you	
Would you like to be added to the Practice Carer Register?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have a designated carer? If so, Please provide details below:	
Name of Carer:	
Contact:	

Your Medical History: Please list all current or past illnesses/operations including dates, where possible:

Heart Disease/Angina		Diabetes	
Epilepsy		High Blood Pressure	
Stroke/TIA		COPD	
Asthma		Cancer	
Dementia		Hyperthyroidism	
Other:			

Family History: Please list all significant medical conditions that your close family members have and please state their relation to you:

Heart Disease/Angina		Diabetes	
Epilepsy		High Blood Pressure	
Stroke/TIA		COPD	
Asthma		Cancer	
Dementia		Hyperthyroidism	
Other:			

Do you have any known allergies? (E.g. antibiotics, food, bee sting, latex)

Yes: ☐ No: ☐ If yes, please state:

Repeat Medications (If applicable):

Drug name:	Dose:

Alcohol use disorders identification test consumption

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times per month	2-3 times per week	4 or more times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	0 to 2	3 to 4	5 to 6	7 to 9	10 or more	
How often have you had 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	

Scoring:

• A total of 5 or more is a positive screen

• 0 to 4 indicates low risk

• 5 to 7 indicates increasing risk

• 8 to 10 indicates higher risk

• 11 to 12 indicates possible dependence

One unit of alcohol



Half pint of "regular" beer, lager or cider



Half a small glass of wine



1 single measure of spirits



1 small glass of sherry



1 single measure of aperitifs

Drinks more than a single unit



2
Pint of "regular" beer, lager or cider



3
Pint of "strong" or "premium" beer, lager or cider



1.5
Alcopop or a 275ml bottle of regular lager



2
440ml can of "regular" lager or cider



4
440ml can of "super strength" lager



3
250ml glass of wine (12%)



9
75cl Bottle of wine (12%)

If your score is 5 or more, you can complete a full audit C screening test here <https://tinyurl.com/y9nu8nh5>
For help about alcohol please call us or visit www.nhs.uk/live-well/alcohol-support

Smoking Status (Please tick one box only)

I am currently a smoker					
I have never smoked					
I am an ex-smoker					
I use an e-cigarette					
How many cigarettes do you/ did you smoke a day?	Less than one 1-9	<input type="checkbox"/> <input type="checkbox"/>	10-19 20-39	<input type="checkbox"/> <input type="checkbox"/>	40+ <input type="checkbox"/>
Would you like help and information to stop smoking? Yes: <input type="checkbox"/> No: <input type="checkbox"/>					

Health Information:

Weight (st/lbs. or kgs)		Height (ft./" or metres)		Blood pressure	
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Women's health:

Are you currently, or think you might be pregnant?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Estimated Date of Delivery if pregnant (EDD)	

Electronic Prescription Service: The practice can send your prescription to your preferred pharmacy electronically. If you have previously nominated a pharmacy in another area and you now wish to change to a local pharmacy, **please inform us of your preferred pharmacy:** _____.

Patient Participation Group:

Would you like to become a member of the PPG?:	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
<p><i>The Barcellos Family Practice Patient Participation Group (PPG) is formed of people from a variety of backgrounds, who each bring something different to the group. Its members are volunteer patients who work with the managers and clinicians at the Practice to support and promote the best possible health care for all patients.</i></p> <p>https://www.barcellosfamilypractice.co.uk/patient-participation-group</p>	

Organ Donation

With effect from 15 March 2020, organ donation in England moved to an 'opt out' system. This means that ALL adults in England will be considered to have agreed to be an organ donor when they die unless they have recorded a decision not to donate or are in one of the excluded groups.

Your family will still be approached and your faith, beliefs and culture will continue to be respected.

You still have a choice about whether or not you wish to become a donor.

Please go to the organ donation website for more information: www.organdonation.nhs.uk

Consent & Data Sharing:

If any of the details on this form change in the future, please inform us. In accordance with the Data Protection Act, the Practice needs consent from any patient for us to leave a message, send a text or information regarding their medical treatment. By providing the information on this form you are consenting to be contacted about your medical needs. The Barcellos Family Practice uses SystmOne clinical software. This enables us to share your record with any other NHS organisations who are involved in your healthcare.

Data Sharing Consent Choices (Summary Care Record & Dorset Shared Record)

To maintain continuity of clinical care, we upload **certain** medical information so that it is available to other healthcare organisations (e.g. Emergency Departments). Please read the accompanying leaflet which details which part of your record is extracted and how it is used to help other NHS organisations.

If you wish to **OPT OUT**, please tick: ☐

Online Services

If you have provided an email address above, you will be **automatically registered** for online services with the Practice through '**SystemOnline**' (incl. prescription requests, booking (select) appointments amending your demographic details and access to your medical records).

If you wish **to opt out**, please tick: ☐

Signed _____

Date: _____