For Surgery use: Date of new patient check appointment : _____/_____/_____

New Patient Health Questionnaire

Dear Patient, thank you for registering with St Catherine's Surgery. Please complete this questionnaire as fully as possible.

Name: ____ Date of Birth ______/______/______

Address: ____

Postcode: ___________________

Telephone Numbers: Home: ______________ / Mobile : _____________________/Work: ___________________

Email address: ____

Maritial Status: __________________________ Occupation: ____

If you have provided a mobile telephone number we will send you a text reminder about your appointments and health care updates. Please tick here if you **DO NOT** consent to this service: _____

Please detail below your chemist if you would like prescriptions to be sent electronically:

Chemist Name: ____ Post code__________________________

To help ensure quality of access to relevant information or communications sent by the surgery, please advise us of any special requirements you may have, for example large print text.

Would you like to be able to book appointments/ order repeat prescriptions on line?: YES/NO
(If yes please fully complete the form on the back page of this questionnaire – **PATIENT ONLINE REGISTRATION**)

Allergies: YES/NO (If yes please provide details below)

Are you a Military Veteran? YES/NO

Do you drink **alcohol**?: YES/NO (If yes please provide details below)

How often do you drink alcohol?:

Monthly or less____ 2-4 times per month ____ 2-3 times per week____ 4+ times per week____

How many units/standard alcoholic drinks do you have on a typical day when drinking?: _____

How often would you have 6 or more alcoholic drinks on one occasion?:

Never ____ Less than monthly ____ Monthly ____ Weekly ____ Daily or almost daily ____

Do you **smoke**?: YES/NO (If yes please provide details below)

How many do you smoke per day?: ____

At what age did you start smoking?: _____

Are you an **ex-smoker**?: Yes/NO (If yes please provide details below)

How many did you smoke per day?: ____

At what age did you stop smoking?: ____

Has anyone in **your family** (father, mother, brother, sister) before the age of 65 suffered from:

Heart Disease (Heart attacks / angina): YES/NO Which family member(s)?: ______________________________

Diabetes: YES/NO Which family member(s)?:______________________________

Asthma: YES/NO Which family member(s)?:______________________________

Stroke: YES/NO Which family member(s)?:______________________________

Cancer: YES/NO Which family member(s)?:______________________________

Site of cancer please: ____

Do you need / have anyone to look after you or your daily needs as a Carer? YES/NO
(If yes please see below)

Would you like them to deal with your health affairs here? YES/NO

Carers Name: __________________________________ Contact Number: _______________________________

Do you care for anyone? YES/NO (If yes please see below)

Would you like information about Carers Support? YES/NO

Do you care for a patient registered at this Surgery? YES/NO (If yes please see below)

Name of patient: ______________________________________ Date of birth: _____/_____/______

Are you interested in joining our **Patient Participation Group (PPG)**?

The PPG meet monthly and offer a platform to review and improve the Surgery provision and also discuss the way local health services are developed.

Would you like to attend the next PPG Meeting? YES/NO (If yes please see below)

Please tick your preferred contact method: Email:______ Text:_____ Post:_____

Ethnic Origin

The UK is an increasingly ethnically diverse society. Information on ethnicity is important because of the need to take into account culture, religion and language in providing appropriate individual care, changing legislation, the importance of providing information on ethnicity for shared care including secondary care and the need to demonstrate non-discrimination and equal outcomes. The experience of the UK Census now means that there are nationally used ethnic categories that have been thoroughly tested and that are now to be acceptable to the majority of the population.

Ethnic Category

White
A - British
B - Irish
C - Any Other White background

Mixed
D - White and Black Caribbean
E - White and Black African
F - White and Asian
G - Any Other Mixed background

Asian
H - Indian
J - Pakistani
K - Bangladeshi
L - Any Other Asian background

Black or Black British
M - Caribbean
N - African
P - Any Other Black background

Other Ethnic Categories
R - Chinese
S - Any Other Ethnic Category

Not Stated
Z - Not Stated

Spoken Language

Akan	Albanian	Amharic
Arabic	Bengali & Sylheti	Brawa & Somalii
British Signing Language	Cantonese & Vietnamese	Creole
Dutch	English	Ethiopian
Farsi (Persian)	Finnish	French
French Creole	Gaelic	German
Greek	Gujarati	Hakka
Hausa	Hebrew	Hindi
Igbo (IBO)	Italian	Japanese
Korean	Kurdish	Lingala
Luganda	Makaton (sign Language)	Malayalam
Mandarin	Norwegian	Pashto (Pushtoo)
Patois	Polish	Portuguese
Punjabi	Russian	Serbian/Croatian
Sinhala	Somali	Spanish
Swahili	Swedish	Sylheti
Tagalog (Filipino)	Tamil	Thai
Tigrinya	Turkish	Urdu
Vietnamese	Welsh	Yoruba

Other: Please specify ______________________________

Patient's Signature: ____ Date: ______/______/_____

For Surgery use only:- Will the patient require an interpreter for appointments? YES/NO

Please details the two forms of official ID provided (one to be photo and one to include address):

____

Checked by: ____ (PRINT YOUR NAME PLEASE)

Patient On Line Application Form for Access to book Appointments and Repeat Medication

Surname	Date of birth
First name	
Address Postcode	
Email address	
Telephone number	Mobile number

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

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐

I understand and agree with each statement (tick)

1. I have read and understood the information leaflet provided by the practice	☐
2. I will be responsible for the security of the information that I see or download	☐
3. If I choose to share my information with anyone else, this is at my own risk	☐
4. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible	☐
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	☐
6. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible.	☐

Signature	Date

1. **For practice use only**

Patient NHS number		EMIS Number
Identity verified by (initials)	Date	Method Vouching ☐ Vouching with information in record ☐ Photo ID and proof of residence ☐
Authorised by		Date
Date account created:		Date passphrase sent: