

**The Hart Surgery – NEW PATIENT QUESTIONNAIRE**

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| First Name(s) | Surname: | Date of Birth: |
| Mobile Telephone: | Email Address:  | Marital Status: |
| Ethnicity:(Eg White British/Other White/Black Caribbean/Black African/Other Black/Chinese/Bangladeshi/Indian/Pakistani/Other Asian/Mixed Race/Other Ethnic Group) | What is your first language?Do you need an interpreter? |

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| **Basic Health Information** |
| Height |  | Do you exercise? | No / Light / Moderate / Heavy  |
| Weight  |  | If you are allergic to anything, please specify  |  |
| Smoker | Yes / No / Ex |
| Blood Pressure |  | Units/week Alcohol | (See overleaf) |

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| **Other Health Information**  |
| It can be several weeks before we receive your medical records from your previous surgery. Is there any significant medical history or current conditions that you GP should be aware of in the meantime?  |  |

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| **Family Health History**  |
| Is there a family history of any of the following?Heart attack | If yes, which family member. Were they under 60? |
| Stroke, Asthma, Hypertension (high blood pressure), Bowel Cancer, Thyroid Problems, Maternal Hip Fracture, Breast Cancer, High Cholesterol, Diabetes, Osteoporosis? | If yes, please give details |

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| **Medication**  |
| Are you on any current regular medication? If yes, please list name of drugs and dosage if known. If possible please attach a copy of your repeat prescription request form. |
| **Electronic Prescription Service:**We can send prescriptions electronically directly to a convenient pharmacy. Your repeat prescription can also be issued using this system. If you would like to sign up for this service please name the pharmacy where you would like to collect your medication: |

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| **Carer Information (if applicable)**  |
| Do you look after someone who is frail, ill or disabled? (unpaid) | If yes please give name, relationship to that person and reason why they need help. Are they also a patient at The Hart Surgery? |
| Do you depend on someone for day-to-day care? | If yes please give name, relationship to that person. Are they also a patient at The Hart Surgery? |

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| **CONSENT***(it helps the surgery reduce its costs if we can contact you by email or mobile telephone).* |
| I agree to the surgery sending me medical or appointment information via email. |  |
| I agree to the surgery sending me medical or appointment information via text message. |  |
| Do you give the surgery permission to divulge your medical details to any specific family member or carers? If yes, please provide their name and the relationship (and contact details if they are not a patient at The Hart Surgery). |
| Are you happy for us to share your basic health information (including medicines, allergies and adverse reactions) across the NHS to assist with your direct personal care? |  |
| 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) |  |

I declare to the best of my knowledge the above is correct.

Patient’s signature: Date: **PTO**



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*PLEASE SPEAK TO A RECEPTIONIST IF YOU WOULD LIKE ONE OF THE FOLLOWING*

* **ONLINE ACCESS**

If you would like to have online access to appointment booking/prescriptions/test results/ medical history, please ask the receptionist for the application form.

* **BLOOD PRESSURE READING**

If you would like a blood pressure reading, please ask at reception to use our BP machine

* **HEALTH CHECK**

If you are aged 40-74 and have not had an NHS health check within the last 5 years and would like one, please ask at reception.

* **NEW PATIENT LEAFLET**

This contains information about the services offered at the surgery. It is also available on our website.

**Weekly Alcohol Consumption**

