YEALM MEDICAL CENTRE

New Patient Questionnaire

Title:_____Forename:_____ Surname:_____ Date of Birth: _____

Address:_____

Mobile Number:_____ Landline:_____

Email Address : _____

Please use your personal mobile number and email address. For data protection purposes we cannot record shared email addresses or mobile numbers.

Preferred Contact Method: ☐ Mobile ☐ Landline ☐ Email

Consent to SMS Messaging: ☐ Yes ☐ No ID Provided: ☐ Driving License ☐ Passport ☐ Utility Bill

Consent to email: ☐ Yes ☐ No

GDPR and Data Sharing:

Summary Care Record (SCR):

This record contains basic information about: Allergies you may have, unexpected reactions to medications and any prescriptions you have recently received. The intention of the SCR is to help clinicians in Emergency Departments and Out of Hours services to give you safe, timely and effective treatment. Clinicians will only be allowed to access your record if they are authorised to do so and, even then, only if you give your express permission. You will be asked if healthcare staff can look at your SCR every time they need to (unless it is an emergency i.e. you are unconscious.)

Please tick **one** of the following options:

☐ Express consent for medications, allergies and adverse reactions

☐ Express consent for medications, allergies and adverse reactions **and additional information**

☐ Express dissent (opt-out)

Clinical System Record Sharing:

Due to GDPR, our clinical system, SystmOne (S1), also requires your permission to permit or restrict access to the information entered into your record at each organisation that accesses your record. You can change your consent at any time. Please tick your preferences:

Do you consent to the sharing of data recorded here with any other organisations that may care for you?

☐ Yes – share with other organisations ☐ No – do not share any data recorded at Yealm Medical Centre

Do you consent to the viewing of data by this organisation that is recorded at other care services that may care for you where you have agreed to make your data shareable?

☐ Yes ☐ No Please sign here to confirm your choices: _____

For Reception: Intials: _____ Date entered on Systm1: _____

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New Patient Questionnaire

Height: _____m Weight: _____kg Waist Measurement: _____cm

Exercise: Do you:

☐ Avoid trivial exercise
☐ Enjoy light exercise (Gentle stroll)
☐ Enjoy Moderate exercise (brisk walk)
☐ Enjoy heavy exercise (running)

Medical History:

Please list any current illnesses (and date of diagnosis if possible):

_____

_____

Are you currently housebound? ☐ Yes ☐ No

If yes, would you like your medication delivered to you? ☐ Yes ☐ No

Do you have any environmental or drug allergies? ☐ Yes ☐ No If Yes, please list them: _____

Do you have a coil, implant or ring pessary fitted? ☐ Coil ☐ Implant ☐ Ring Pessary ☐ N/A

When was your last cervical smear? _____

When was your last tetanus injection? If you do not know a specific date, please guesstimate: _____

Do you have a disability, impairment or sensory loss? Please state diagnosis: _____

Family History: Have any of your close relatives suffered from any of the below:

High Blood Pressure (Hypertension) ☐ Yes ☐ No **Relation:** _____

Heart Disease under 60 years: ☐ Yes ☐ No **Relation:** _____

Heart Disease over 60 years: ☐ Yes ☐ No **Relation:** _____

Smoking information:

Have you ever smoked? ☐ Yes ☐ No **If yes, please select the appropriate box below**

Current Smoker

☐ Less than one a day
☐ One to nine a day
☐ 10 – 19 a day
☐ 20 – 39 a day
☐ 40 or more
☐ Cigars/ Pipe

Do you want to quit?

☐ Yes ☐ No

Ex - Smoker

☐ Less than one a day
☐ One to nine a day
☐ 10 – 19 a day
☐ 20 – 39 a day
☐ 40 or more
☐ Cigars/ Pipe
☐ Amount unknown

We offer Smoking Cessation advice with the Health Care Assistant. Would you like an appointment?

☐ Yes ☐ No

Dispensary and Medication information:

Our practice dispenses to patients who live more than **one mile in a straight line** from a pharmacy. If you live within one mile in a straight line of a pharmacy, we are **unable** to dispense the medication here. We deliver medication to housebound patients and nursing on request.

Do you live within one mile in a straight line from a pharmacy? ☐ Yes ☐ No

If yes, please tell us your local pharmacy: _____

Safeguarding Information:

Do you receive support from any other professional agency? **(e.g., probation services, mental health teams, domestic abuse services, social services)** ☐ Yes ☐ No

If Yes, please list them: _____

Have you accessed support from any other professional agency in the last three months? ☐ Yes ☐ No

If Yes, please list them: _____

Do you require support to access the agency specified due to relocation? ☐ Yes ☐ No

If Yes, please list them: _____

Main Spoken Language: _____ Ethnic group: Please tick below your ethnic group.

☐ Arab ☐ Bangladeshi ☐ Chinese ☐ Indian ☐ Pakistani ☐ Black African ☐ Black Caribbean ☐ Irish Traveller ☐ Mixed Race ☐ Other Asian ☐ Other British Black ☐ Other White Background ☐ White and Asian ☐ White and Black African ☐ White and Black Caribbean ☐ White British ☐ White Irish

If you do not want your ethnicity recorded please tick here: ☐

Signed: _____ **Date:** _____

If you have filled this form out on behalf of another patient (ie you are their parent or carer) please fill out this information:

Name: _____ **Date of Birth:** _____

Accessible Information Standard:

Please visit www.england.nhs.uk/accessibleinfo for more information regarding:

- British Sign Language interpreters
- Text, voicemail and email communication regarding appointments, health campaigns, results etc.

We use Sign Solutions for interpreters. Visit their website: signsolutions.uk.com

We have a large print practice booklet available on request and a communication widget. Please state if you require any further information or have any communication needs:

Devon Carers:

We have access to a free service for Devon Carers. You can contact them on **03456 434 435** or visit their website at www.devoncarers.org.uk.

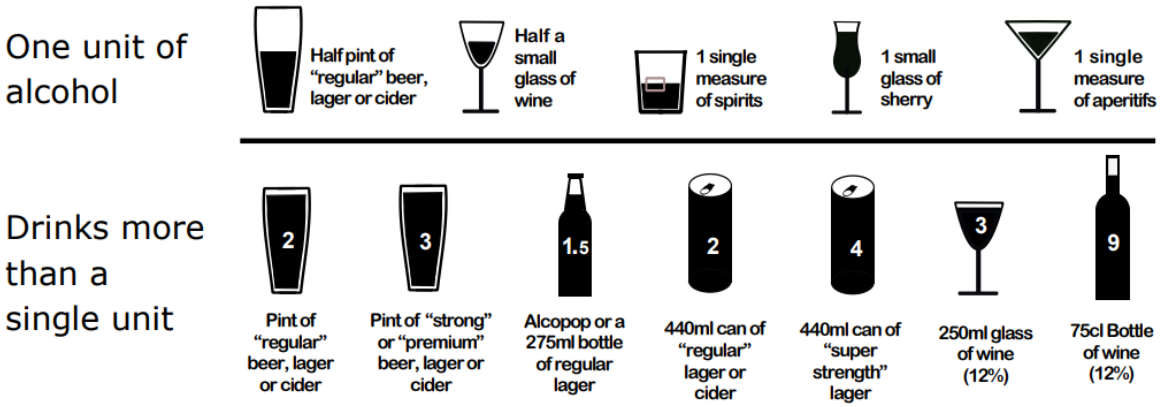
Are you a carer without receiving payment? Let your GP know. If you are a carer, please state their name and GP surgery.

Caree name: _____ Caree's GP Surgery: _____

Participation Virtual Group:

Would you like to become more involved in decisions about services provided by your practice? The Participation Virtual Group is looking to recruit new members of all ages to become involved in their group. The means of communication is email and they will only contact you from time to time for feedback relating to their service. To get involved, please email d_ccg.yealmppg@nhs.net

ALCOHOL SCREENING TOOL



Alcohol use disorders identification test consumption (AUDIT C)

This alcohol harm assessment tool consists of the consumption questions from the full alcohol use disorders identification test (AUDIT).

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 to 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	

AUDIT C score	

Scoring:

- A total of 5 or more is a positive screen
- 0 to 4 indicates a low risk
- 5 to 7 indicates an increasing risk
- 8 to 10 indicates a higher risk
- 10 to 12 indicates a possible dependence

What to do next: if you have a score of 5 or more please complete the remaining alcohol harm questions below to obtain a full AUDIT score.

Remaining AUDIT assessment questions:

AUDIT Questions (after completing 3 AUDIT-C questions above)	**Scoring system**					**Your score**
	0	**1**	**2**	**3**	**4**	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody 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 or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					TOTAL	

Scoring:

- 0 to 7 indicates low risk
- 8 to 15 indicates an increasing risk
- 16 to 19 indicates a higher risk
- 20 or more indicates possible dependence