Central Gateshead Medical Group

New Patient Questionnaire – for patients aged 16 years & over

Please complete this form when you register with us. It usually takes a number of weeks before your medical records arrive from your old GP Practice, so this form can help us with essential medical information about you.

If you take regular medication, you will require an initial GP appointment – after this appointment you may be able to order your prescriptions without the need to see a GP.

Please complete this form in **BLOCK CAPITALS**

Personal Information

Title : _____ Forename (s) : _____ Surname : _____

Date of Birth : _____ Place of Birth : _____

Address : _____

_____

Post Code : _____ Telephone No. : _____

Marital Status : _____ Mobile No : _____

Email address: ----------

Are you happy to receive SMS text messages and emails about your care/appointments from the practice? YES / NO

PLEASE NOTE: We will **not** pass your data to any third party

Previous GP

Name : Dr _____ Address : _____

Area : _____ Tel No. : _____

Ethnic Origin / Nationality

Please tick (✓) the appropriate boxes :

○ White	○ British ○ European ○ Other	○ Black	○ African ○ Caribbean ○ Other
○ Other	○ Indian ○ Pakistani ○ Bangladeshi	○ Chinese ○ Other (Inc mixed origin)	
○ Refuse to submit Ethnic Status	What Country were you Born : _____	What is your main language spoken : _____	What is your Religion : _____

Do you require an Interpreter? YES / NO

If **YES**, which language do you speak?

Medical information
Do you have any of the following conditions? (Please tick all that apply)

☐ Coronary Heart Disease (ie Angina, heart attack, MI etc) ☐ Diabetes type 1 ☐ Diabetes type 2

☐ Hypertension/High blood pressure ☐ Hyperthyroidism/Thyroid problems

☐ Asthma ☐ COPD (chronic bronchitis)

☐ Stroke/TIA ☐ Cancer (please state type) ……

☐ Epilepsy ☐ Mental Illness

If you have any of the above conditions, do you know the date of your last review? ……

The practice operate an annual review system for certain Long Term Conditions and will invite you to make an appointment (usually around the month of your birthday).

Medication
Please supply a list of the medications you are currently taking. (Copy of current prescription if possible). If you are unsure about the name of the drug, please include a brief description why you are taking the medication.
You must see a GP for your 1st prescription. After this you will be able to order repeat prescriptions if appropriate.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Other Important Information

Do you currently smoke: YES / NO -- if "YES" how many per day: _____

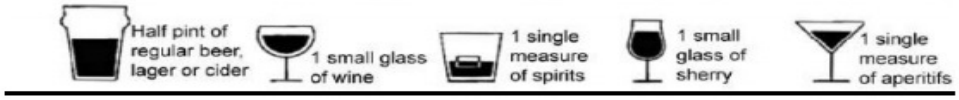
If you would like support/advice in trying "giving up" please make an appointment with one of our Health Care Assistants

Do you have any known Allergies : YES / NO
(please include any medications which have caused a bad reaction when you have taken them and type of reaction)

1. _____
2. _____
3. _____
4. _____
5. _____

Using the guide below, how many units of alcohol do you drink per week? ☐

This is one unit of alcohol...



...and each of these is more than one unit

Please answer the questions below:

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

SCORE ☐

A score of 5 or more indicates increasing or higher risk drinking.

If you score 5 or more please continue:

Questions	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	

SCORE ☐

Add both scores together: TOTAL SCORE ☐

If you would like support/advice about your alcohol intake please make an appointment with one of our Health Care Assistants

Do you have a Carer : YES / NO -- if "Yes" : The name of your Carer : _____

Relationship of Carer : _____ Contact Details : _____

Are you a Carer : YES / NO -- if "YES" : The name of the person you look after : _____

A carer is someone of any age who provides UNPAID practical & emotional support to someone who cannot manage day to day activities due to their age, illness, mental ill health, physical or learning disabilities, alcohol or substance misuse

Are you or have you ever been a member of the armed forces?: YES / NO
(anyone who has served in the Army, Royal Air Force, Royal Marines or Royal Navy)

If you have answered YES do you consent for this to be recorded in your medical records? YES / NO

Communicating with our patients

We want to get better at communicating with our patients. We want to make sure you can read and understand the information we send you.

We want to know if you have any communication or information needs relating to a disability, impairment or sensory loss.

If you find it hard to read our letters or if you need someone to support you at appointments, please let us know.

We want to know if you need information in braille, large print or easy read.

We want to know if you need a British Sign Language interpreter or advocate.

We want to know if you need an interpreter.

We want to know if we can support you to lip-read or use a hearing aid or communication tool.

Do you require any information or communicate support?

Yes / No

If yes, please state what we can do to help communicate with you in the best possible way, or ask to speak to reception in private

We will enter the above information to your medical records to ensure we do all we can to communicate with you/send information to you in the best possible way.

Patient Participation
We have an e-forum, in order that we can send patients via email, practice newsletters which will contain latest practice information & news, along with useful topics and hints.
Throughout the year, we want to be able to obtain feedback from patients who visit the practice in order for us to understand if we are delivering the services you require and how we can improve the service to you as a patient.

If you have supplied an email address we will use this to contact you. You can opt out at any time by contacting the practice.
(we will not divulge your email address to any other 3rd party)

I understand and accept that the information that I have included within this pre-registration questionnaire will be used by the practice and included within my medical records.

Signature : _____ Date : _____