UPMINSTER MEDICAL CENTRE

New Patient Health Questionnaire

We are a summary care records practice

SURNAME: _____ FORENAMES: _____

DOB: _____ OCCUPATION: _____

FULL ADDRESS: _____

_____ POSTCODE: _____

RELIGION: _____ NHS No (if Known): _____

HOME TEL NO: _____ MOBILE NUMBER: _____

EMAIL ADDRESS: _____ MARITAL STATUS: _____

Are you happy to receive information from us by either text or email? YES ◯ NO ◯

What is your Height: _____ How much do you Weigh: _____

Next of Kin: Name: _____

Next of Kin: Tel. No: _____ Relationship to patient: _____

Previous GP Name: _____

Address: _____

We need to know your smoking history:

Please tick one of the following:

Smoker ☐ How many per day? _____

Ex-smoker ☐ Date you stopped? _____

Never smoked ☐

Which of the following best describes your diet?

Please tick one of the following:

Healthy ☐ Vegan ☐

Vegetarian ☐ Specialist ☐
(please give details)

Unhealthy ☐ _____

_____

We need to know your alcohol intake:

Wine ☐ Beer ☐ Spirits ☐

How often do you have a drink containing alcohol?

Never ☐ 2-3 times a week ☐

Monthly or Less ☐ 4 or more times a week ☐

2-4 times of month ☐

Monthly ☐

What best describes the amount of exercise you do?

Please tick one of the following:

Inactive ☐ Gentle ☐

Moderate ☐ Vigorous ☐

Women only:

Please circle where appropriate

When was your last cervical smear? _____

What was the result? _____

Is there any family history of breast / cervical / ovarian or womb problems? Yes No

If yes, please give details:

_____

_____

ARE YOU PREGNANT? _____ Expected date of Delivery: _____

Are you currently taking the oral contraceptive pill? Yes No

Briefly list any significant past / current medical history:

i.e.: Asthma, Diabetes, Angina

Serious illness: **When?**

_____

_____

_____

_____

_____

_____

_____

Briefly list any operations undertaken:

Operations: **When?**

Are you currently taking any medication prescribed by the doctor?

If so, please give name of medication and dose

Are you allergic to any medication / food / animals?

Please give details:

We need to know your family medical history:

Which of your blood relations have suffered from the following (please tick appropriate boxes):

Heart attack			High blood pressure		
Cancer			Stroke		
Diabetes			Tuberculosis		
Asthma			Other major illnesses		
			Please specify		

Electronic Prescription Service (EPS):

Please note that we are one of the first Practices in the area who started to operate Electronic Prescription Service. If you would like us to send your prescriptions electronically to a Pharmacy of your choice, then please ask the staff at the Reception on how to nominate your Pharmacy and join EPS.

Patient Access Online:

A. If you would like to automatically register for Patient Access Online Services – **"Do Nothing"**

Benefits of Patient Online Access:

- Order repeat prescriptions online;
- Book up to 2 appointments with the doctor or nurse of your choice;
- View a Summary of your Medical Record held on our clinical systems including
  - any Allergies;
  - any acute and/or repeat medications;
  - any laboratory tests once these have been viewed by a doctor and filed into your medical record;
  - any immunisations; etc.

B. Do you want to Opt out of registering for Patient Access Online Services - YES ◯

Patient ethnic origin questionnaire:

This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act.

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your ethnic origin may help with the early identification and diagnosis of some of these conditions.

Ethnic Origin
Please tick only one of the following:

White British	☐	Black Caribbean	☐
White Irish	☐	Black African	☐
White Scottish	☐	Black British	☐
White Welsh	☐	Black West Indian	☐
White & Black Caribbean	☐	Black – Other	☐
White & African	☐		
White & Asian	☐	Chinese	☐
Other Mixed	☐		
		Other	☐
Indian/British	☐	Please specify	☐
Pakistani/British	☐		
Bangladeshi/British	☐	I do not wish to	
Other Asian	☐	disclose my ethnicity	☐

What is your first spoken language? _____.

If other than "English", do you require an interpreter? Yes ☐ No ☐

Signature: _____

Date: _____

As from 28th August 2013 our practice is providing "Summary Care Records" to the "Out of Hours" service/Accident & Emergency for emergency use only.