THE DOVE VALLEY PRACTICE **NEW PATIENT QUESTIONNAIRE**

It may be some time before we receive you medical records from your previous GP. Please complete this questionnaire before seeing the GP or Health Care Assistant, as it will help us with your medical care.

SURNAME…….. FIRST NAMES……

ADDRESS…… DATE OF BIRTH……

……. TELEPHONE NO.……...

……. OCCUPATION……

MARITAL STATUS: Single/Married/Separated/Divorced/Widowed/Other

DO YOU HAVE A CARER?…….

ARE YOU A CARER? …….

HAVE YOU EVER WORKED IN THE COAL MINES? YES/NO

SMOKING STATUS Never smoked /Ex-smoker/Current smoker – number per day _____
**IF YOU SMOKE DO YOU NEED HELP TO STOP? WE OFFER A SMOKING CESSATION SERVICE – PLEASE ASK THE RECEPTIONIST FOR AN APPOINTMENT.

Do you have any special requirements ie are you registered disabled/blind/partially sighted/deaf?
YES/NO – please provide details……...

Do you have any allergies to medicines/tablets/food/other YES/NO
If YES, please give details:
……..

Please list any medication you are currently taking <u>(a list from your GP would be very useful)</u>
……

……

ETHNIC ORIGIN: (Please tick)

	Tick		Tick
A – White		**D – Black or Black British**	
British		Caribbean	
Irish		African	
Other White		Other Black	
B – Mixed		**E – Other ethnic group**	
White & Black Caribbean		Chinese	
White & Black African		Any other ethnic group	
White & Asian			
Other mixed		**What is your main spoken language?**	
C – Asian or Asian British			
Indian		**<u>Do you need an interpreter?</u>**	
Pakistani		**YES NO**	
Bangladeshi			
Other Asian			

Data Protection Patient Consent - Please choose below your most appropriate form of contact

*I am happy/*I am not happy (delete as necessary) for staff/GPs at Dove Valley Practice to leave a message with a third party or on my answer machine and contact me via SMS text message. I will inform you should this situation change.

Signed: _____ Date: _____

Name: _____ Date of birth _____

THIS SECTION MUST BE COMPLETED OTHERWISE REGISTRATION WILL BE DELAYED

Parental Responsibility

If this registration request relates to a child under the age of 16 years, please provide details of who has parental responsibility and if they live at a different address

Name…… Relationship to child……

Address……

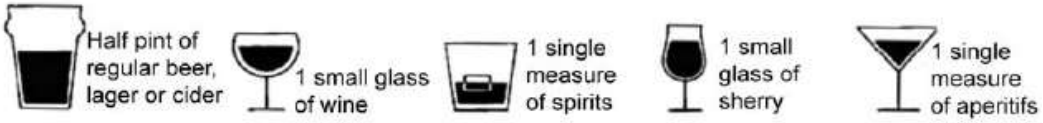
……

……

Please complete the table below by ticking or circling the boxes that are relevant to you;

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	

This is one unit of alcohol...



You have asked to join our practice as a new patient, we would like to make you aware of the following in order to make the registration process run smoothly for you and for us;

1) If you are fit and well, and not on regular medication, you will be invited to a health check with one of our Health Care Assistants. This is not essential and if you don't want an appointment with the HCA please tick the box and sign below** **However, if you make an appointment but do not attend your registration may be cancelled.**

2) If you are on regular repeat prescription ie, creams, tablets, inhalers etc **you MUST see one of our Doctors before your next prescription is due otherwise your registration may be cancelled,** your previous Doctor should have given you enough medication to last for at least 4 weeks. If you have your repeat prescription list from your previous Doctor, please give it to our Receptionist so that it can be photocopied for our records, if not please bring it to your appointment. We can't issue medication without seeing proof of what you are taking, this is a matter of safety and not honesty. If you are under the care of Substance Misuse you will need to make your appointment with Dr C Liley, our Lead GP in Substance Misuse.

If you are taking regular, repeat medication, you will need to make an appointment with the Doctor and you must bring all your medication with you (including any creams or lotions).

**I am not taking any repeat, regular medication and I do not wish to have a routine health check ☐

Signed…… Date…….

Please note that you can access your medical records, arrange your appointments and order repeat prescriptions on-line. If you would be interested in registering for this service, please ask for details at reception. Thank you

FOR OFFICE USE ONLY

Checklist for Receptionist

Have you checked that the patient lives within the practice boundaries? YES/NO

Have you provided the patient with a new patient pack including GMS1, questionnaire, summary care information, patient leaflet, patient participation leaflet?

Are all the relevant fields of the registration form (GMS1) and new patient questionnaire completed?

GMS1 registration form

The following details must be filled in:

Status	Previous surname (if applicable)
Sex	Previous address in the UK inc postcode
Surname	Previous GP while at that address
Forename	Are they from abroad?
Date of birth	If so, the date when first came to live in the UK
Marital status	Are they returning from armed forces?
Address inc postcode	If so, the enlistment date
Telephone number	Patient signature

Have you booked the appropriate appointment? Please enter details below

	Date	Time
New patient check	_____	_____
Doctor	_____	_____
Nurse	_____	_____
Midwife if pregnant	_____	_____

Have you explained how the appointment system works? Yes ☐ No ☐

Receptionist signature _____ Date _____

Patient details;

Name _____

Address _____

Date of birth _____