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? …………………………………………………………………….

SMOKING STATUS I have never smoked/I am a current smoker/I am an ex-smoker

Do you have any of the following medical conditions?

ARTHRITIS	YES/NO	ASTHMA	YES/NO
CANCER	YES/NO	CHRONIC BRONCHITIS	YES/NO
DEPRESSION	YES/NO	DIABETES	YES/NO
EPILEPSY	YES/NO	HIGH BLOOD PRESSURE	YES/NO
THYROID TROUBLE	YES/NO	STOMACH ULCER	YES/NO
STROKE	YES/NO	TUBERCULOSIS	YES/NO
HEART ATTACK	YES/NO	ANGINA	YES/NO

Are you registered disabled? YES/NO

Are you registered blind/partially sighted? YES/NO

If you have had any illnesses not listed above, or any operations or accidents in the past, please give details below:

DESCRIPTION PLACE/HOSPITAL DATE

……………………………………………………………………………………………

……………………………………………………………………………………………

Are you currently receiving treatment for a medical problem, i.e.: under the care of the hospital, or GP? If so, please give details below:

………………………………………………………………………………………………

………………………………………………………………………………………………

………………………………………………………………………………………………

Please complete the questions overleaf.

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 (a list from your GP would be very useful)

……

……

FOR WOMEN ONLY:

Are you using contraception? YES/NO.

If YES, which form of contraception are you using? ....

What was the date and result of your last smear test? ....

Have you had a hysterectomy? YES/NO If YES, which year?………………………………

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		**Do you need an interpreter?**	
Pakistani			
Bangladeshi		**YES NO**	
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. I will inform you should this situation change.

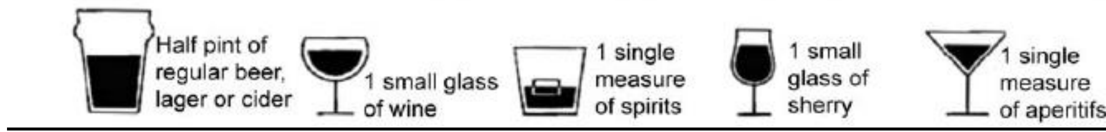
Signed: ______________________________ Date: ____________________________

Name: ______________________________ Date of birth _____________________

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 above** **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…………………….

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
Sex
Surname
Forename
Date of birth
Marital status
Address inc postcode
Telephone number

Previous surname (if applicable)
Previous address in the UK inc postcode
Previous GP while at that address
Are they from abroad?
If so, the date when first came to live in the UK
Are they returning from armed forces?
If so, the enlistment date
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 ____