

# PARK-LEYS MEDICAL PRACTICE

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## New Patient Questionnaire

Please complete this form as fully as possible. The information requested will help us to provide you with the best possible service and will be treated as part of your medical records.

We offer all new patients the opportunity to have a new patient check with a Nurse or Healthcare Assistance. Please make an appointment if you would like to have a brief check up with one of our staff.

**Are you, or do you have a carer? If so please complete a Carer Consent Form. Ask at Reception**

### Patient Details

Surname:	Forenames:
Date of birth:	Sex: <b>M / F</b>
Mobile Phone Number :	Email Address :
Home Phone Number :	Key Code (if applicable):

**If you have any Allergies AND/OR Significant illness please list below:-**


**BP: (Please use machine in reception)**

**Please provide a copy of your regular repeat medication request slip - obtainable from your current GP**

**Family Medical History.** Do any of your mother, father, brother or sister suffer from any of the following?

Stroke	Y / N	Diabetes	Y / N	Breast Cancer	Y / N
Bowel Cancer	Y / N	Asthma	Y / N	Heart Disease	Y / N

### Female Patients Only

Have you had a cervical smear?	Y / N	Date of Last Test?
What was the result of the smear test?		
Do you use contraception?	Y / N	If Yes, method?

**What is your Ethnic Group ?**

**What is your first language?**

Signed:	Date::
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PARENTS'/ CARER'S NAME (FOR PATIENTS UNDER 16 ONLY):


Do you suffer from any of the following?

	Tick Below	Date First Diagnosed
Asthma		
Heart disease		
Diabetes		
Epilepsy		
High blood pressure		

Are you a smoker or have you ever smoked? Y / N Give details below

What and how much do/did you smoke?

Are you: a smoker  ex smoker  never smoked

If a current smoker, how many do you smoke per day?

When did you stop?

If you are interested in information on giving up smoking please see the practice nurse.

How often do you have a drink containing alcohol?

Never  Monthly  2-4 times  2-3 times  4+ times   
Or less  per month  per week  per week

How many units of alcohol do you drink on a typical day when you are drinking?

1-2  3-4  5-6  7-8  10+

How often have you had 6 or more units if FEMALE, or 8 more if MALE on a single occasion in the last 6 months ?

Never  Less than  Monthly  Weekly  Daily or almost daily   
Monthly

## SUMMARY CARE RECORDS

### **PATIENT CONSENT FORM**

Dear Patient,

Following your request to register as a new patient at our practice, we are required to ensure you have the correct information recorded on your computer records regarding your Summary Care Record and your wish to consent/decline to share your information (**MEDICATION, ALLERGIES AND SENSITIVITIES only**) with other NHS Organisations.

**IN ORDER FOR THIS TO TAKE PLACE, PLEASE TICK ONE OF THE BOXES BELOW, AND SIGN AND RETURN THIS FORM WITH YOUR PATIENT REGISTRATION FORM.**

**I WISH TO CONSENT TO MY SUMMARY CARE RECORDS BEING SHARED WITH OTHER NHS ORGANISATIONS.**

**I DO NOT WISH MY SUMMARY CARE RECORDS TO BE SHARED WITH OTHER NHS ORGANISATIONS.**

**PATIENTS NAME .....**

**PATIENTS SIGNATURE .....**