EVERGREEN OAK AND CREEKMOOR SURGERIES

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NEW PATIENT QUESTIONNAIRE - ADULT

Please complete all pages in FULL using BLOCK capitals

Surname

First Names (in full)

Previous Surnames

Title Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Male ☐ Female ☐

Date of Birth (DD/MMM/YY) NHS Number

Town & Country of Birth

Address

Postcode:

Telephone Number Mobile Number

Email Address

Please help us trace your previous medical records by providing the following information:

Previous Address in UK

Postcode:

Name of Previous Doctor

Address of Previous Doctor

Postcode:

Are you arriving/returning from abroad:

Your first UK address where registered with a GP

Postcode:

If previously resident in the UK, what is your date of leaving?

What date did you come to live in the UK?

If you are returning from the Armed Forces:

Address before Enlisting

Postcode:

Enlistment Date Service Number

Ethnicity and First Language Details:

Please indicate you ethnic origin:

British or mixed British	☐	Carribean	☐	Bangladeshi	☐	
American	☐	Indian	☐	Chinese	☐	
African	☐	Irish	☐	Other (please state)	☐	
Asian	☐	Pakistani	☐	Decline to state	☐	

Please indicate your first language:

English	☐	Italian	☐	Russian	☐	Other (please state)	☐		
French	☐	Polish	☐	Arabic	☐				
German	☐	Greek	☐	Hindi	☐	Decline to state	☐		☐
Spanish	☐	Dutch	☐	Japanese	☐				

NHS Organ Donor Registration:

I would like to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.

☐	Any of my organs and tissue	☐	Heart	☐	Corneas	☐	Pancreas
☐	Any part of body	☐	Liver	☐	Lungs	☐	Kidneys

Signature to confirm agreement to organ/tissue/body part donation

Signature _____ Date _____

For more information. Please visit the website www.organdonation.nhs.uk or call 0300 123 23 23

NHS Blood Donor Registration:

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.

Signature to confirm consent to inclusion on the NHS Blood Donor Register

Signature _____ Date _____

For more information about the NHS Blood Donor Register, please visit www.blood.co.uk or call 0300 123 23 23

Please tell us about yourself:

Are you a carer? Yes ☐ No ☐ Do you have a carer? Yes ☐ No ☐

If yes, please tell us the name and address of your carer

Postcode:

Additional Needs:

Do you suffer from any form of disability? If so, please provide details:

Do you consider yourself to be housebound? Yes ☐ No ☐

Do you regularly use a walking stick, walking aid or wheelchair to get about? Yes ☐ No ☐

Do you require any extra help with Communication (not including foreign language needs)? Yes ☐ No ☐

If yes, please ask Reception staff for the Additional Communication Questionnaire

Allergies and Sensitivities:

Please list any allergies or sensitivites you may have:

Personal Medical History:

Have you ever suffered from any important medical illness, operation or emergency admission to hospital?

Condition	Date/Year	Ongoing
		Yes / No
		Yes / No

Family Medical History:

Have any close relatives *(father, mother, sister, brother only)* ever suffered from any of the following: Please tick

Heart Attack	Stroke	Diabetes	High BP	Asthma	Glaucoma	Cancer
☐	☐	☐	☐	☐	☐	☐

Immunisation:

Are you fully immunised? Yes ☐ No ☐ Don't know ☐

Have you two doses of the MMR (Measles, Mumps & Rubella) vaccine? Yes ☐ No ☐

If you are unsure or have NOT had two doses of the MMR, you may be susceptible to infection with the rubella virus (German Measles). This infection in pregnancy can cause severe abnormality and even the death of the baby. We offer a dose of MMR vaccine to all who have not completed a course. (Please note this cannot be given in pregnancy as it is a live vaccine)

Would you like to book a MMR vaccination? Yes ☐ No ☐

Medication:

If you have a copy of your repeat medications, please list below or pass a copy to Reception staff with this form.

Medication	Dosage	Medication	Dosage

Prescription requests must be made in writing. We do not accept requests over the phone. However, you can order medication 24/7 using a SystmOnline Account. Sign up form is at the front of this registration.

In order to save YOU, the patient, time, you can use the Electronic Prescribing Service (EPS) which allows your scripts to be sent electronically to a nominated pharmacy. Please nominate a pharmacy below:

Female Patients only

Have you had a cervical smear test? Yes ☐ No ☐ Date (if known)

Have you had a hysterectomy? Yes ☐ No ☐ Date (if known)

Have you had a mammogram? Yes ☐ No ☐ Date (if known)

Lifestyle

Please enter your height, current weight and blood pressure if available:

Your height Your weight Blood Pressure

Lifestyle - Smoking

Do you smoke? Yes ☐ No ☐ If yes, how many?

What do you smoke? Cigarettes ☐ Cigars ☐ Pipe ☐

Are you an ex-smoker? Yes ☐ No ☐ When did you give up?

Smoking seriously damages your health

For help and advice on quitting, please contact Live Well Dorset or contact them on 0800 840 1628

Lifestyle - Alcohol

Please complete the following questions about alcohol by circling the appropriate box

One drink = 

Question	Scoring System			
	0	1	2	3
How often do you have a drink that contains alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-8
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly

Scoring: A total of 5+ indicates hazardous or harmful drinking

Lifestyle - Exercise

How often do you exercise?	No exercise	Yes ☐	No ☐
	Light exercise: 1-3 times per week	Yes ☐	No ☐
	Moderate exercise: 3-5 times per week	Yes ☐	No ☐
	Heavy exercise: 5+ times per week	Yes ☐	No ☐

Patient Participation Group

We are keen to ensure our patients are actively involved in helping us provide the best possible service to all our patients. The aim of the PPG is to give patients the opportunity to express their experiences and views of the care thay have received and also exchange ideas with the practice on how services could be developed and improved.

Would you like to join the Patient Participation Group Yes ☐ No ☐

Next of Kin

Name _____ Contact Telephone Number _____

Relationship _____

Signature

I confirm the information I have provided is true to the best of my knowledge.

Signature _____ Date _____

Signature of patient ☐ Signature on behalf of patient ☐

Thank you for taking the time to complete this registration form. Please hand to Reception staff when completed

For administrative use only

NHS Blood and Organ Donor ☐

Patient Details ☐

Form checked and coded ☐

Form scanned ☐