

MARKET HARBOROUGH & BOSWORTH PARTNERSHIP

ADULT NEW PATIENT QUESTIONNAIRE

Thank you for applying to join Market Harborough & Bosworth Partnership. We would like to gather some information about you and ask that you fill in the following questionnaire. You don't have to supply answers to all of the questions but what you do fill in will help us give you the best possible care.

Please supply two forms of Identification with your completed form, a photographic form of ID (such as passport or driving license) and proof of your home address (such as a recent bank statement or document relating to your new home dated within the last three months).

Please complete all areas in CAPITAL LETTERS and tick the appropriate boxes.

Fields marked with an asterix (*) are mandatory.

*Title	Marital status
*Surname	*First names
*Home telephone No. Preferred Number <input type="checkbox"/> Yes <input type="checkbox"/> No	*Date of Birth
Mobile telephone No. Preferred Number <input type="checkbox"/> Yes <input type="checkbox"/> No	*Home Address & Postcode
Work telephone No. Preferred Number <input type="checkbox"/> Yes <input type="checkbox"/> No	Email Address:

Staff please check rest of the form and sign, date and state I.D seen on last page.

Next of kin \ Emergency contact

Name of next of kin \ Emergency contact

Relationship to you

Next of kin \ Emergency contact telephone number(s)

Next of kin \ Emergency contact address (if different to above)

*Do you consent to receive the following types of communication from Market Harborough and Bosworth Partnership?

I consent to receiving SMS Mobile phone text messages Yes No

I consent to answer machine messages Yes No

Surgery use only
*If **NO** (opt out of SMS) code EMISNQCO73 & add onto SMS on registration screen and give patients details to Natalie P.*

*If **NO** to answer machine messages code EMISNQDE129 & put alert on patients record to state either consent or not to surgery leaving answer machine messages.*

Additional details about you

First Language :

If English is not your first language, please state first language

Do you require an interpreter?

Surgery use only –code 9NU
(Put alert on patients record to state interpreter required, which language & language line number and access code for GP) Double appointment required.

What is your ethnic group? Please tick appropriate box.

British or Mixed British	<input type="checkbox"/>	Irish	<input type="checkbox"/>	Other white background	<input type="checkbox"/>
White & Black Caribbean	<input type="checkbox"/>	White & Black African	<input type="checkbox"/>	White & Asian	<input type="checkbox"/>
Other Mixed Background	<input type="checkbox"/>	Indian or British Indian	<input type="checkbox"/>	Other Asian Background	<input type="checkbox"/>
Caribbean	<input type="checkbox"/>	African	<input type="checkbox"/>	Other Black Background	<input type="checkbox"/>
Chinese	<input type="checkbox"/>	Bangladeshi or British Bangladeshi	<input type="checkbox"/>	Pakistani or British Pakistani	<input type="checkbox"/>
Other (please state)					
Ethnic Category not stated					

Have you ever been in the employment of the Armed Forces? Yes (13Ji)

Data Sharing

Summary Care Record (SCR)

The SCR is an electronic record summary held on the central NHS database. It provides authorised care professionals with faster, secure access to essential information about you when you need care i.e. medications you are currently receiving.

More information can be found by visiting: <http://systems.digital.nhs.uk/scr>

Tick this box if you wish to have a Summary care record (code 9Ndm)

Tick this box if you wish to **opt out** of having a Summary Care Record (code 9Nu0)

Risk Stratification Preferences

Risk stratification is the process of identifying the relative risk of patients in a population by analysing their medical history. It's a key enabler for improving the quality of care delivered by the NHS. Market Harborough & Bosworth Partnership is taking part in the Risk Stratification programme and will be uploading patient identifiable data for analysis. Patient identifiable information will only be viewable at GP practice level. Any NHS organisation external to the practice using risk stratification will only see anonymised data.

For more information please visit our website at marketharboroughmedicalcentre.co.uk

Tick this box if you wish to **opt-out** of the Risk Stratification programme (9nu4)

You can change your mind at any time by informing the practice

Carers Information

A carer is a friend or family member who gives their time to support a person in their home, to an extent that the person could not remain at home if this care was not being provided. A carer can receive Carers Allowance, but not a wage and the care they are giving will significantly affect their own life.

Are you looked after by someone who's support you could not manage without?

Yes No

IF YES, what is their name relationship to you and their contact number?

Name

Relationship to you.....

Contact number

Do you consent for your carer to be informed about your medical care? Yes No

Do you have a Power of Attorney? Yes Documents Yes

Name

Relationship to you.....

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Patient has a carer 918F

Patient has a Power of Attorney 9W & add details of person with POA to descriptive text box

Do you look after or support someone who couldn't manage without you? Yes

If yes, do you look after someone who is a patient of Market Harborough & Bosworth Partnership?

Yes No Don't know

If yes, what is their name

Are they a: Relative Friend Neighbour

Surgery use only

Patient is a carer 918G & add details of person cared for to descriptive text box

Medical details

If you are taking prescribed medication, please make an appointment to see your doctor within two weeks and bring your medicines with you. (We will not be able to issue any repeat prescriptions until you have seen a doctor.)

*Are you allergic to any medicines? Yes No (if yes please specify)

*List other allergies / intolerances (i.e. nuts, gluten, pollen, animal hair or certain foods. Please mark "none" if you have no other allergies that you know of)

Have you ever had any of the following conditions?

Epilepsy	<input type="checkbox"/> Yes	Year	Mental Illness	<input type="checkbox"/> Yes	Year
High Blood Pressure	<input type="checkbox"/> Yes	Year	Diabetes	<input type="checkbox"/> Yes	Year
Heart Attack / Angina	<input type="checkbox"/> Yes	Year	Asthma	<input type="checkbox"/> Yes	Year
Stroke / Mini-stroke (TIA)	<input type="checkbox"/> Yes	Year	COPD (or Emphysema)	<input type="checkbox"/> Yes	Year
Cancer	<input type="checkbox"/> Yes	Year	Osteoporosis / Bone fractures	<input type="checkbox"/> Yes	Year
Rheumatoid Arthritis	<input type="checkbox"/> Yes	Year	Peripheral vascular disease	<input type="checkbox"/> Yes	Year

Do you have any of the following?

Coil	<input type="checkbox"/> Yes	Date of procedure		615p <input type="checkbox"/>
Implant	<input type="checkbox"/> Yes	Date of procedure		61KA <input type="checkbox"/>
Pessary	<input type="checkbox"/> Yes	Date of procedure		7D1B6 <input type="checkbox"/>
Pacemaker	<input type="checkbox"/> Yes	Date of procedure		ZV450 <input type="checkbox"/>

(For women only)

If you are pregnant please make an appointment to see your doctor as soon as possible, so that the ante-natal care can be arranged for you.

Do you have any disabilities, illnesses or accessibility needs? i.e use of a specific communication device such as a hearing aid? If yes, please tell us how we can support your needs.

The Accessible Information Standard (AIS)

Please use this space to tell us about any specific communication needs you have. I.e. needing information in large print or deaf blind telephone contact. For further information please visit <https://www.england.nhs.uk/ourwork/accessibleinfo/>

Do you have family history of any of the following?

High Blood Pressure	<input type="checkbox"/> Yes	Who	DVT / Pulmonary Embolism	<input type="checkbox"/> Yes	Who
Ischaemic Heart Disease Diagnosed aged >60 yrs	<input type="checkbox"/> Yes	Who	Breast Cancer	<input type="checkbox"/> Yes	Who
Ischaemic Heart Disease Diagnosed aged <60 yrs	<input type="checkbox"/> Yes	Who	Any Cancer Specify type:	<input type="checkbox"/> Yes	Who
Raised Cholesterol	<input type="checkbox"/> Yes	Who	Thyroid disorder	<input type="checkbox"/> Yes	Who
Stroke / CVA	<input type="checkbox"/> Yes	Who	Epilepsy	<input type="checkbox"/> Yes	Who
Asthma	<input type="checkbox"/> Yes	Who	Osteoporosis	<input type="checkbox"/> Yes	Who

Please tell us about your lifestyle

Do you smoke? Yes No

If Yes, what do you primarily smoke:

Cigarettes / Electronic cigarettes/ Cigar / Pipe (please circle)

How many do you smoke a day?.....

Would you like advice on quitting?

Yes No

Are you an ex-smoker Yes No

Over 3years? Yes No

Approximately how much do you weigh?

Approximately how tall are you?.....

Do you exercise regularly? Yes No

Please tick ONE of the below:-

Exercise physically impossible Yes

Enjoy light exercise Yes












Enjoy moderate exercise Yes

Enjoy heavy exercise Yes

Please record any additional information about you that you think is important for us to know

Please tell us about your alcohol consumption

The recommended safe allowance is 14 units for both men and women per week

1 UNIT	1.5 UNITS	2 UNITS		3 UNITS	9 UNITS	30 UNITS
 Normal beer half pint (284ml) 4%	 Small glass of wine (125ml) 12.5%	 Strong beer half pint (284ml) 6.5%	 Medium glass of wine (175ml) 12.5%	 Strong beer Large bottle/can (440ml) 6.5%	 Bottle of wine (750ml) 12.5%	 Bottle of spirits (750ml) 40%
 Single spirit shot (25ml) 40%	 Alcopops bottle (275ml) 5.5%	 Normal beer Large bottle/can (440ml) 4.5%		 Large glass of wine (250ml) 12.5%		

How many units of alcohol do you drink on average per week?

Please complete Audit C below

Questions (please circle your answers)	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 - 4 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		
<u>TOTAL SCORE OF ABOVE =</u>							
<p>Scoring:- A total score of 5+ indicates increasing or higher risk drinking. An Overall score of 5 or above is AUDIT –C positive.</p> <p><u>If your score is 5 or above please complete the consumption audit on the following page.</u></p>							

CONSUMPTION AUDIT

(please complete if you scored 5+ on the previous alcohol questions)

Score from Audit C (previous page)

Remaining AUDIT questions

Questions	Scoring system					Your score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
YOUR TOTAL SCORE =						

Surgery use only

Scoring: 0 – 7 Lower risk,

8 – 15 Increasing risk = brief intervention

16 – 19 Higher risk = brief intervention

20+ Possible dependence = See GP/Offer referral

*In accordance with the Data Protection Act, the practice needs consent if you are happy for a 3rd party to collect prescriptions, test results and other medical information on your behalf. Please complete this section if you would like to register a 3rd party.

I give consent for

Relationship to me ----- to collect prescriptions on my behalf (Please note that we are unable to hand out prescriptions to anyone under the age of 15)

I give consent for.....

Relationship to me.....to obtain test results / medical information / appointment information on my behalf (Delete as appropriate)

IT IS YOUR RESPONSIBILITY TO ADVISE US OF ANY CHANGES TO THESE INSTRUCTIONS:

Signed:

Date:

Surgery use only

If Yes to Prescriptions code 9qA & add details to descriptive text box & put alert on pt record

If Yes to test results / medical information/ appts code 9NdG & add details to descriptive text box & put alert on patients record.

New Patient Health-check

Patients who are 45 and over will be offered a review with the Practice Nurse/ Health Care Assistant in order to have a general health check including blood pressure, urine dip test and to take details of height, weight, smoking and alcohol consumption along with any other relevant medical information including family history. Contact reception if you should like to take this up.

Free NHS Health Check for Patients Between The Ages of 40 and 74:

Helping you prevent heart disease, stroke, diabetes, kidney disease, and dementia.

Patients between the ages of 40 and 74 are entitled to have a Free NHS Health Check every five years.

Even if you're feeling well, it's worth having your NHS Health Check now. We can then work with you to lower your chances of developing these health problems in the future.

If you would like a Health Check and **have not got one of the conditions mentioned above** please tick the box and we will send you more information and an invite letter:

Please sign and date your form

*Signed

*Date

**Signed on behalf of patient (*if applicable*)
(e.g. adults lacking capacity)**
.....
Print name

.....
Relationship to patient
.....

Once you are registered...

If there are any problems with your registration we'll contact you to clarify any issues, but once your details have been entered into our computerized records:-

On-line Services

You will be able to register with our on-line service and access appointments, prescriptions and some sections of your own medical record via the internet. All of the details that you need for this are available by requesting to be registered at the registration desk.

Patient Participation Group. (PPG)

We are keen to encourage our patients to make a positive contribution to the services and facilities offered at the Market Harborough & Bosworth Partnership and have set up a Patient Participation Group (PPG).The group currently consists of 10 patients from different diverse patient groups. We would particularly like younger people and/or teenagers to join the group. The idea is to work with the medical, nursing and other support staff within the practice to raise any ideas and issues and to help patients take more responsibility for their own health.

Currently the Patient Participation Group meets bi-monthly. A PPG Notice Board is situated in the surgery waiting area, which will include details of PPG activities and minutes of PPG Meetings.

For surgery use only

DATE

STAFF SIGNATURE

PHOTO ID TYPE:

ADDRESS ID TYPE:

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ALL CODING & ALERTS FROM FORM ACTIONED

DATE

STAFF SIGNATURE