MARKET HARBOROUGH & BOSWORTH PARTNERSHIP
New Patient Registration Questionnaire

Welcome to Market Harborough & Bosworth Partnership. Please complete this questionnaire in as much detail as possible, as it can take several weeks for your medical records to reach us. The information you give will be treated in strict confidence and will help us provide you with appropriate medical care.

PLEASE NOTE, WE CANNOT REGISTER YOU UNTIL WE HAVE RECEIVED A FULLY COMPLETED QUESTIONNAIRE.

If you are 45 or over and would like a new patient check please make an appointment with reception. The enclosed Practice Booklet will give you more information on this.

DATE……..

1. Personal details or details of dependents you are completing this form for:

NAME: ……..…….. DOB: ……...…

TITLE (PLEASE SPECIFY) MR/MRS/MISS/MS ……

MARITAL STATUS…….

ADDRESS: …… HOME TEL No: ……..

……. MOBILE TEL No: ……..

……. E-MAIL: ……..

POSTCODE: …… OCCUPATION: …….

2. Next of kin:

NAME: ……. RELATIONSHIP TO YOU: ……..

ADDRESS:
…….

POSTCODE: …….. CONTACT TEL No: ……..

3. Summary Care Record:

We have the ability to share information entered on your medical records with other healthcare organisations – i.e Accident and emergency departments, walk in centres and out out-of-hours centres.

Allowing other healthcare organisations to see a summary of your medical records can help to provide you with appropriate care especially in an emergency situation.

The Summary Care Record will contain information about any medicines you are taking, any allergies and any bad reactions to medicines you have had to ensure those caring for you have enough information to treat you safely.

As a patient you have a choice:

Do you consent to the sharing of data recorded at Market Harborough & Bosworth Partnership with any other organisations that may care for you?

Please note that children under 16 will automatically have a Summary Care Record created for them unless their parent or guardian completes an opt out form on their behalf requesting us to consider opting them out. If you are the parent or guardian of a child under 16 and feel they are old enough to understand then you should make this information available to them.

Yes ☐ **No** ☐ Please complete the attached opt out form.

Signed: …… Date:……

You can change your choice at any time by informing the practice.

4. Ethnic Group:

The Department of Health has asked us to record the ethnic origin of all new patients.

This information will be added to your medical record.

If you do not wish to provide this, please tick the Information refused' box at the following list.

Ethnic Origin (Please tick the description which you feel is most appropriate).			
British or Mixed British		**Other Mixed Background**	
African		**Other White Background**	
Bangladeshi or British Bangladeshi		**Other**	
Caribbean		**Pakistani or British Pakistani**	
Chinese		**White and Asian**	
Indian or British Indian		**White and Black African**	
Irish		**White and Black Caribbean**	
Other Asian Background		**Information Refused**	
Other Black Background			

5. First Language:

If English is not your first language, please state first language:. …….

Do you require an interpreter? Yes/No

6. Disabilities:

Please give details of any disabilities that you have, relating to:

EYESIGHT……HEARING……

MOBILITY…….LEARNING……..

7. Carers:

Are you a Carer? (Please give details, including approx. hours per week) ……

Are you the main carer? Yes/No

A carer is someone who for 14 hours a week or more is responsible for looking after a relative or friend who, because of disability, illness or old age, cannot manage without help.

Please give details of the person you care for:

NAME: ……. ……. TITLE: (PLEASE SPECIFY) MR/MRS/MISS/MS ……

ADDRESS: …… HOME TEL No: ……..

…….. MOBILE TEL No: ……...

POSTCODE: ……. RELATIONSHIP: ……

PLEASE INDICATE IN WHAT WAY YOU CARE FOR THIS PERSON:

……..

……

8. Are you an Armed Forces Veteran? Yes/No

9. Health:

Please answer the questions relating to any conditions you have:

√	CONDITION	QUESTION
	Asthma or other breathing problem (e.g COPD)	Date of last spirometry test Today's peak flow measurement
	Blood Pressure	
	Cancer	Type of Cancer Date of Diagnosis
	Diabetes	Date of last visit to optician Date of last visit to podiatrist/chiropodist
	Epilepsy	Date of last full daytime seizure (fit) Date of next hospital follow-up appointment
	Heart (angina, previous heart attack etc)	What kind of heart problem do you have?
	Kidney (renal problems)	
	Mental health problems	Name of consultant and/or CPN Do you take Lithium?
	Operations	Please specify any operations you have had
	Stroke/mini stroke	Date of Stroke (s)
	Thyroid (Under or Over Active)	Do you take thyroxine? Date of last blood test
	Allergic reaction (rash, Anaphylactic shock)	What are you allergic to?
	Have you any of the following: Coil, Implant, Pessary, Pacemaker	Date of Procedure:

Have you ever had a bad allergy or reaction to any medicines? (If so, give 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).

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: ☐

10. Family History:

Have any members of your immediate family (parents, brothers and sisters) had any of the following medical problems?

CONDITION	YES / NO	CONDITION	YES / NO
BREATHING		BLOOD PRESSURE	
CANCER		DIABETES	
HEART		STROKE/MINI STROKE (please specify)	
Please state reason why family history may not be given (E.G Adoption) :			

11. Ladies only:

LAST SMEAR (DATE)		LAST SMEAR (RESULT)	
LAST MAMMOGRAM (DATE)		LAST MAMMOGRAM (RESULT)	
METHOD OF CONTRACEPTION			
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.			

12. Lifestyle:

Approximately how much do you weigh? …….....

Approximately how tall are you? …….

Do you follow any special diet eg. Vegan, low fat etc? ……

How many cigarettes or ounces of tobacco do you smoke per day? ……..

Obviously smoking increases the risks of a number of serious health problems including heart disease and cancer, we advise everyone who smokes to quit. We offer clinics to help people quit smoking some of which are in the evening. If you are interested in quitting ask at reception or speak to your doctor.

If you do not smoke, have you ever smoked in the past? Yes/No

If you used to smoke, please state how much and when you quit: …….

What form(s) of exercise do you take (eg walking, swimming etc) ……

How long each time? ……. How many times per week? …….

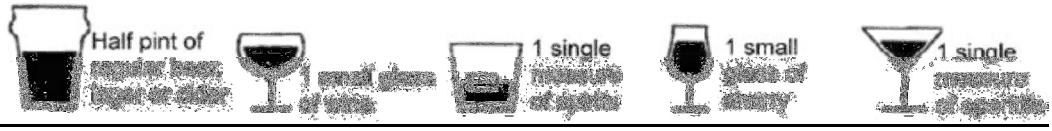
How many units of alcohol do you drink on average per week? ……

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

Pint of regular Beer/Lager/Cider = **2 units**
Alcopop or Can of Lager = **1.5 units**
Glass of Wine(175ml) = **2 units**
Bottle of wine = **9 units**
Single measure of spirits = **1 unit**

APPENDIX 3

This is one unit of alcohol…

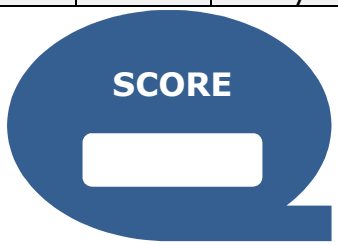


…and each of these is more than one unit

AUDIT – C

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	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.



CONSUMPTION AUDIT

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	

Scoring: 0 – 7 Lower risk,
8 – 15 Increasing risk = brief intervention
16 – 19 Higher risk = brief intervention
20+ Possible dependence = See GP/Offer referral