MONKSEATON MEDICAL CENTRE
NEW PATIENT QUESTIONNAIRE

Today's Date ………………………………..

Photographic ID checked ☐

WELCOME to Monkseaton Medical Centre. **Please fill in this questionnaire as carefully as possible and hand it to the receptionist with photographic ID**. This information helps us offer you the best possible service so please complete as much of it as you can, but it does not have to be perfect!

The information in this form is part of your STRICTLY CONFIDENTIAL medical records.

If you take medication regularly, please ensure that you have at least 1 month's supply of your medication from your previous GP practice. It can take several months for your medical records to be transferred to your new GP practice.

You do not need to have new registration health check, but you are welcome to make an appointment with one of our Health Care Assistants who can discuss this form with you, where they will measure your height, weight and blood pressure and advise you about lifestyle and whether any further investigations would be of benefit.

If you have an ongoing disease or are at risk of heart problems and eligible for a NHS Health Check, our nursing team will contact you and invite you for an appointment.

We would like to register you for online services to enable you to order prescriptions online and book appointments online. If you do not want to register for online services please inform the receptionist.

CONTROLLED DRUGS POLICY

Please note, it is the policy of this practice not to prescribe high doses of morphine or opiates and issue repeat prescriptions for medicines which can be addictive. Examples of these drugs have CD after their name, but also include benzodiazepines, 'z' drugs, painkillers and gabapentin. Patients taking these medicines will be contacted by a member of the pharmacy team to discuss reducing and stopping these medicines.

VISITS POLICY

We encourage patients to attend the surgery whenever possible as Home visits, whilst convenient, actually offer a poorer standard of care compared to surgery consultations (see the practice leaflet or website for more information). However, GPs do offer visits for:

Terminally ill patients – we have no problems at all seeing those who are at most clinical need

Truly bedbound patients – we have no problems seeing those who are confined to bed

So poorly would be harmed if moved- we have no problems at all seeing those who are at most clinical need.

Please tick here to say that you have understood the visit policy YES [ ]

Electronic Data Sharing (please refer to the patients guide in your welcome pack)
Do you consent to the information that is recorded about you here being made available to other NHS Care services that care for you and also you System1? YES [ ] NO [ ]

Do you consent to allow Monkseaton Medical Centre to view information about you that has been recorded at other services where you also receive care? YES [ ] NO [ ]

ETHNIC ORIGIN ……………………………………………………………………………………………

British/Mixed British		Chinese	
White/Black Caribbean		Other Ethnic Non-mixed	
White/Black African		Other Black Ethnic Group	
Black, other non-mixed origin		Other Asian Ethnic Group	
Black – other mixed		Irish Ethnic Group	
Indian/British Indian		Other Ethnic Group	
Pakistani/Black Pakistani		Other White	
Bangladeshi/British Bangladeshi			

COMMUNICATION …………………………………………………………………………………………………...

Do you need help communicating? YES [ ] NO [ ]

Interpreter or sign language ☐ Hearing impaired ☐ Visually impaired ☐ Any other…………………

TITLE: ……… NAME ……………………………………DATE OF BIRTH…………………………………..

ADDRESS
………

POST CODE ………………………………………………………………………………………………

Email Address: ……………………………………………………………………………………………

TEL NO Home No: …………………………………Mobile No: ………………………..……………….

NAME AND ADDRESS OF PREVIOUS GP
………..

………..

NEXT OF KIN………………………………………………………………………………………………

ADDRESS OF NEXT OF KIN………………………………………………………………………………..

PERSONAL HISTORY
What is your marital status?
Single ☐ Married ☐ Divorced ☐ Widow/er ☐ Live alone ☐ Live with someone☐

Who else is living in your household at the moment? (E.g. wife, children, elderly relatives) ………………….

…….

What is your occupation? ………………………………………………………………………………

Children under 16 please give name of School…………………………………………………………

ALCOHOL INTAKE
Do you drink alcohol? YES ( ) NO ( )
This is one unit of alcohol…

Half pint of regular beer, lager or cider

1 small glass of wine

1 single measure of spirits

1 small glass of sherry

1 single measure of aperitifs

If yes how much?

Questions	0	1	2	3	4	Your score *
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 8 or more units 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.

SMOKING STATUS

Never Smoked ☐
Ex- Smoker ☐ Date stopped smoking: ………………………………………………
Smoker ☐

CARERS' REGISTER –A Carer is anyone (irrespective of age) who has the responsibility for the care of a person (partner, relative or friend) who has mental health problems, learning difficulties, is physically disabled or whose health is impaired by sickness or drug or alcohol problems, or who is elderly or frail. Carers may provide a range of practical and emotional support either in their own home or in the home of the person they care for. A parent carer is a parent of a disabled child who has additional needs.

15a	Are you a Carer?			Yes ( ) No ( )	
If the answer is yes, please give details of who you care for:					
Name		D.O.B.		GP	
Address: (if the person you care for does not live with you) Tel. No.					
Tell us what illness (es) the person you care for has?					

15b	Does someone care for you?	Yes ( ) No ( )			
If the answer is yes, please give details of your carer					
Name		DOB		GP	
Address of your carer Tel. No.					
Are you able to get to the surgery to see GP and nurses there?					

In order to maintain accurate records should your status as a carer or someone who is cared for, or someone who cares for you changes, please inform your GP practice so that records can be kept up to date.

MEDICAL HISTORY

Are you allergic to any drugs or medicines? Please give details …………………………………………

Are you allergic to anything else? Please give details ……………………………………………………...

Do you have a disability? If yes, please give details ………………………………………………………..

	YES	NO
Have you had a NHS Health Check in the last 5 years?	[ ]	[ ]

Please list any previous serious illness, operation, or accidents.

Year Details

At our practice we send our prescriptions electronically, please inform us of your chosen chemist

……

Do you have any of the following:	Yes	No
Asthma or chest problems	[ ]	[ ]
Cancer	[ ]	[ ]
Chronic kidney problems	[ ]	[ ]
Diabetes	[ ]	[ ]
Epilepsy	[ ]	[ ]
Heart Problems (Atrial fibrillation, angina, previous heart attacks, heart failure)	[ ]	[ ]
High Blood Pressure	[ ]	[ ]
Learning Disability	[ ]	[ ]
Memory Problems	[ ]	[ ]
Mental Health Problems	[ ]	[ ]
Rheumatoid Arthritis	[ ]	[ ]
Stroke	[ ]	[ ]
Thyroid problems	[ ]	[ ]

Please list any current medical problems (not listed above).

FEMALE PATIENTS ONLY:

13a	Have you had any pregnancies?	If yes, how many?	Dates
13b	Have you had a cervical smear?	Yes ( ) No ( )	Date
	Would you like one?	Yes ( ) No ( )	
13c	Have you had an abnormal smear that needed treatment?	Please give date(s)	Name of hospital who treated you
13d	Do you use contraceptive? If so which?	Oral contraceptive pill Yes ( ) No ( )	Other (please specify)
13e	If you are aged 50 or over, have you had a mammogram (breast x-ray)?	Yes ( ) No ( )	Date
13f	If you have had a mammogram what was the result of the x-ray?		

DRUGS AND MEDICATION

Please note, it is the policy of this practice not to prescribe high doses of morphine and other harmful drugs and issue repeat prescriptions for medicines which can be addictive. Patients taking these medicines will be contacted by a member of the pharmacy team to discuss reducing and stopping these medicines

What medicines of any kind are you taking at present – whether prescribed or bought by yourself? It would be very helpful to bring your repeat prescription side slip and mark for the attention of our pharmacy team – this will ensure your repeat medications are transferred as soon as possible to our system.

Drug name	Strength	How many taken each day

FAMILY HISTORY

Has your mother, father, brother or sister suffered any of the following? (Please tick as appropriate)

	Yes	No
High blood pressure	[ ]	[ ]
High Cholesterol	[ ]	[ ]
Diabetes (sugar)	[ ]	[ ]
Asthma	[ ]	[ ]
Heart disease under 55 years of age	[ ]	[ ]
Blood disorders	[ ]	[ ]
Cancer	[ ]	[ ]
Stroke	[ ]	[ ]

Practice use only:

Please complete new patient questionnaire template

ID checked ☐
Accountable GP allocated coded (XacWQ) ☐
Height Weight BP

Enhanced Care record shared ☐
Informed of accountable GP coded (Xab9D) ☐
Lifestyle advice offered ☐

Further investigations or clinical advice required

Comments: