BAY MEDICAL GROUP

EMIS NO: _____

New Patient Questionnaire (v16)

Welcome to Bay Medical Group.

To register with this Practice, please complete this questionnaire as fully as possible. The questions have been designed to help your new GP get to know you and your medical history. It may take some time for your previous medical records to reach us. The information you give will help us to provide you with good medical care.

PERSONAL DETAILS			
Title	Mrs/Miss/Ms/Mr	Forename(s)	
Surname		Address	
Date of Birth			
NHS number			
Home Tel. No.		Postcode	
Mobile Tel No.		Email	
Work Tel. No.			

Do you consider yourself to have a disability?	Yes ☐ No ☐	
Details of impairment:	Physical Impairment ☐	Sensory Impairment ☐
Learning Disability/Difficulty ☐	Mental Health Condition ☐	Other ☐
Please give more information:		

Do you require any communication assistance?					
Large Print	☐	British Sign Language	☐	Interpreter (please specify)	☐
If an interpreter is necessary please inform us each time you book any appointment					
Are you EX Military?	Yes ☐ No ☐	Please provide your service number:			

CHILDREN UNDER THE AGE OF 18 For each child under 18 years, please state name and contact details for the main carer and state relationship of the carer to the child (eg mother, father)

Name of child	Relationship to child	Contact Details:

Ethnicity - How would you describe your ethnicity?

White	British ☐	Irish ☐	Other white ☐		
Asian	Asian British ☐	Bangladeshi ☐	Indian ☐	Pakistani ☐	Other Asian ☐
Black	Black British ☐	African ☐	Caribbean ☐	Other black ☐	
Mixed	Asian & White ☐	Asian & Black ☐	Asian & Caribbean ☐	White African ☐	White Caribbean ☐
Other	Chinese ☐	Japanese ☐	Middle Eastern ☐	Turkish ☐	Other ethnicity ☐

Please advise us of your First Language	English ☐	Other *(please state)*	
Do you have a second language?	YES ☐ NO ☐	Please State:	

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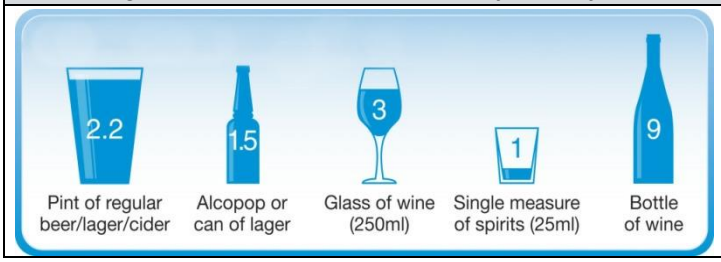
HEALTH DETAILS					
If you are unable to provide your BP now, there is equipment in the waiting room at Morecambe Health Centre to record your blood pressure and weight, please write your name and date of birth on the back of the slip and post in the provided box.					
Blood pressure	/ mmHg	Height	m	Weight	kg
Are you a smoker?	Yes ☐ No ☐	How many a day?			
Would you like support and/or information on giving up?		If yes, please ask reception for an advice leaflet			
Stopped smoking?	Yes ☐ No ☐	When?			
Never smoked?	Yes ☐ No ☐				

Alcohol - Alcohol use can affect your health and can interfere with certain medications and treatments.
Your answers will remain confidential so please be honest.
Use the guide below to decide how many **units** you drink a week.



Do you drink any alcohol?	Yes ☐ No ☐
How many **units** / week?	

Alcohol Questionnaire

Only to be completed if you answered 'Yes' to drinking alcohol

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.

If you score 5 or higher, please complete more detailed questionnaire overleaf.

SCORE

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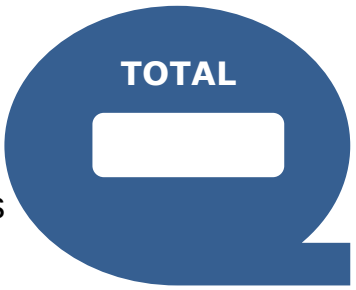
Score from AUDIT- C (other side)

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?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or regret 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,
16 – 19 Higher risk, 20+ Possible dependence

TOTAL Score equals
AUDIT C Score (above) +
Score of remaining questions



If your score is 8 or above and you would like to discuss this further please contact reception who can make you an appointment with our in-house Alcohol Team.

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Medical History Do you have, or have you had, any serious health problems (including operations) / long term conditions?			
		Details	**Date** (if known)
Asthma	☐		
Cancer	☐		
COPD	☐		
Chronic Kidney Disease	☐		
Diabetes Type 1	☐		
Diabetes Type 2	☐		
Epilepsy	☐		
Heart Condition	☐		
High blood pressure	☐		
High cholesterol	☐		
Osteoporosis	☐		
Stroke	☐		
Mental health problems	☐		
Thyroid Problems	☐		
Circulation problems	☐		
Other serious illnesses	☐		
Any operations	☐		

Allergies do you have an allergies? If so please give details			Yes ☐ No ☐
Allergic to		Details of the reaction	

Family History - Have any of your immediate relatives (brothers/sisters/parent) had any of the following? *Please tick boxes and give details if you can*			
		Details	**Relationship**
Heart attack or angina before age 60	☐		
Heart attack or angina over age 60	☐		
Asthma	☐		
Diabetes	☐		
Stroke	☐		
Cancer	☐		
Any inherited diseases	☐		

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Hospital Care (The doctor may discuss with you the possibility of transferring your care to a local hospital)				
Are you currently under hospital care?	Yes ☐ No ☐		If 'Yes', then complete below	
Hospital Name	**Name of Consultant**	**Nature of Problem**		
Are you a carer?	Yes ☐ No ☐	If yes, who for?		
Is someone a carer for you?	Yes ☐ No ☐	If yes, who for?		

FEMALES ONLY					
Date of last cervical smear?		Are you pregnant?	Yes ☐ No ☐		
Have you had a hysterectomy?	Yes ☐ No ☐				
Contraception - what is your current method of family planning?					
Not Applicable	☐	Coil (date fitted _____)	☐	Injection	☐
Contraceptive Pill	☐	Sterilisation	☐	Implant (date fitted _____)	☐
Condom	☐	Partner had vasectomy	☐	Hysterectomy	☐

✂----------CUT ALONG THIS LINE IF APPLICABLE----------

Appointments - please book the following appointments if applicable once your registration is processed		
If you would you like a Well Person Health Check?	20 minute appointment with a Healthcare Assistant (HCA) ☐	
If you have asthma/ COPD?	30 Minute Appointment with Asthma/COPD Nurse ☐	
If you have diabetes	20 Minute Appointment with HCA ☐ Followed by 30 Minute Appointment with a Diabetic Nurse ☐	
If you have heart disease or high blood pressure	20 Minute Appointment in HCA ☐	
If you want to quit smoking	Ask for Advice Leaflet at reception ☐	
If you are currently under hospital care	Appointment with GP required ☐	
If you are aged 40-74 and do not have heart disease, including hypertension, and/or Diabetes (and do not take a statin)	Appointment for a NHS Health Check ☐	

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Repeat medication		
Are you on any repeated medication?	Yes ☐ No ☐	
If "Yes", do you have a repeat prescription slip from your previous GP?	Yes ☐ No ☐	
If "Yes", please hand it in at Reception. If "No" then list below any current medication you are taking and make sure you show Reception all your medication in its original packaging and labelling. We may need to contact your previous GP surgery to confirm your medication.		

Name of drug	*Frequency (how often taking it)*	*Reason for using drug*

Electronic Prescription Service (EPS)

Your electronic prescriptions can now be sent direct to a nominated pharmacy. You must nominate your chosen pharmacy for this to happen.

Please write below the name of the Pharmacy you would like your Electronic Prescriptions to be sent to:

_____

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Data Sharing & Online Services

Bay Medical Group offers Internet facilities for booking GP appointments, ordering repeat medication and viewing your medical records online. You need to be registered in order to access this service. You can *only* apply for yourself and must be aged 16 and over.

Bay Medical Group takes the responsibility for your confidential medical information very seriously.

This form offers you the opportunity to express your wishes as to whether or not you would like your medical record to be shared. In addition if you have a mobile telephone number you will receive appointment reminders and other health promotional text messages, you can opt out of this service below.

If you would like access to our online services then you can apply for this as well. We are seeking your permission for the following:

1. **SMS Messaging Service (0-5 year old & Over 16's only)**
2. **Patient Access registration (Over 16 years of age only)**
3. **Summary Care Record (SCR) - opt out**

Please be aware if you do not complete these forms, we will assume you give consent to the above but will not be registered for online services.

I am completing this form for myself: ☐

I am a carer completing this on behalf of the patient: ☐

PATIENT DETAILS					
Title	Mrs/Miss/Ms/Mr			Male ☐ Female ☐	
Surname		Forename(s)			
Address					
Postcode		Date of Birth			
NHS number		Email			
Home Tel. No.		Work Tel. No.			
Mobile Tel. No.		Please ensure you inform the surgery of any changes			

CARER DETAILS (Please only complete this if you are the carer completing this form on behalf of the patient)					
Title	Mrs/Miss/Ms/Mr			Male ☐ Female ☐	
Surname		Forename(s)			
Address					
Postcode		Date of Birth			
NHS number		Email			
Home Tel. No.		Mobile			

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SMS MESSAGE SERVICE		
Would you like to receive text messages from BMG? **(0-5 years old and *Over 16's only)***	Yes ☐ No ☐	If yes, sign to consent
I consent to receiving appointment confirmations, reminders and other notices via text messages and will update the Surgery of any changes to my mobile number.		
Signature (Patient/Parent/Guardian)		Date

ONLINE SERVICES (PATIENT ACCESS)	
I agree to use the system in a responsible manner in accordance with all instructions given to me by the practice. If not, access may be withdrawn.	Yes ☐ No ☐
I agree that it is my responsibility to keep secure the username and passwords I will be given. If I think these have been shared inappropriately I will reset them using the instructions supplied.	Yes ☐ No ☐
I agree that my details below may be used to contact me with information about my online account and the online services I use.	Yes ☐ No ☐
I agree that online services are provided at the discretion of the practice, and may be withdrawn by the practice at any time.	Yes ☐ No ☐
I understand that I cannot use this service as a means of communication with the surgery for other purposes and will not use it for urgent matters.	Yes ☐ No ☐

Please select the services you would like:			
Appointment Booking	☐	Repeat Medication	☐
Please give the name of the Pharmacy who you would like your Electronic Prescriptions to be sent to:			

Declaration:
Please supply me with my registration details to allow me to access Online Patient Services. I understand that I am responsible for securing these details to prevent unauthorized persons from accessing my account online. In the event that my security details have been compromised I will inform the Practice immediately so that access can be blocked and a new password issued. If at any time I wish to permanently cease Internet access I will inform the practice in writing.

Signature (Patient/Parent/Guardian)		Date	

MEDICAL RECORD VIEWER
Once you are fully registered with the Practice, you can apply to view your medical record online using a separate form. Information regarding this will be including in your welcome letter. Once an application is submitted you records are reviewed by a GP before being activated. Please be aware this can take up to 4 weeks at peak holiday periods.

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SUMMARY CARE RECORD (SCR)

The NHS in England has introduced the Summary Care Record, which will be used in emergency care. The record will only contain information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had to ensure those caring for you have enough information to treat you safely.

Your Summary Care Record will be available to authorised healthcare staff providing your care anywhere in England, but they will ask your permission before they look at it. This means that if you have an accident or become ill, healthcare staff treating you will have immediate access to important information about your health.

Bay Medical Group is supporting Summary Care Records. As a patient you have a choice:

If you would like a Summary Care Record then you do not need to do anything and a Summary Care Record will be created for you. **If you do not want a Summary Care Record** then sign the opt out below.

For more information please visit: **www.nhscarerecords.nhs.uk,** or telephone the dedicated NHS Summary Care Record Information Line on 0300 123 3020.

SUMMARY CARE RECORD OPT-OUT
Only sign if you want to opt out

I do *NOT* want a Summary Care Record

Signature (Patient/Parent/Guardian)		Date	

Thank you for completing this questionnaire. Please, give it to one of the Receptionists.

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TO BE COMPLETED BY RECEPTIONIST				
Proof of identity	Passport ☐	Identity card ☐	Photo Driving license ☐	Other ☐
Proof of address	Utility bill ☐	Bank statement ☐	Tenancy agreement ☐	Other ☐
Photocopied by Reception	Yes ☐ No ☐	Passport/Driving License No.		
Anti-smoking leaflet given	☐	Printed BP and weight slip	☐	
Name of staff member:			**Date:**	
Signature of staff member:				

FOR INTERNAL USE ONLY:

- Reception - please pass completed New Patient Questionnaire to the Scanners.
- Scanners - please scan and then pass the original to IT.

IT Team:

- Once patient is added to system - send Pages 1-5 to HCAs for coding.
- Task MMT is patient is on repeat medication (unless medication already on the system).
- Deal with Pages 7-9, code if the patient has dissented from either SCR, deal with SMS consent if necessary and activate Patient Access if patient has requested and ID has been checked.