**WELTON FAMILY HEALTH CENTRE – NEW PATIENT QUESTIONNAIRE FOR OVER 16’s**

Welcome to WELTON FAMILY HEALTH CENTRE. Please help us by completing this questionnaire in full as it may take some time for your medical records to reach us. All information will be treated as strictly confidential and we require you to complete this questionnaire fully before we are able to process your request for registration.

**PERSONAL DETAILS**

|  |  |  |
| --- | --- | --- |
| **FULL NAME**:(inc. title) |  | MALE: [ ] FEMALE: [ ]  |
| **ADDRESS:**(inc. postcode) |  | **Date of Birth**: |
|  |
| **Home Tel. Number**: |  | Please **√** if you agree to be contacted by: |
| **Mobile Tel. Number**: |  | **TEXT**  | **Yes** [ ]  **No** [ ]  |
| **Email Address**: |  | **EMAIL** | **Yes** [ ]  **No** [ ]  |
| **Work Tel. Number**: |  |  |

|  |  |
| --- | --- |
| **Previous Doctor’s Name and Address**: |  |

|  |
| --- |
| **Please tick (√) the box that best describes your ethnic origin.** This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of one of these conditions. |
| **WHITE**White British White Irish Any other white background **MIXED**White and Black Caribbean White and Black African White and Asian Any other mixed race  | [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  | **ASIAN OR ASIAN BRITISH**Indian Pakistani Bangladeshi Any other Asian background **CHINESE** Chinese Any other  |  [ ] [ ] [ ] [ ] [ ] [ ]  | **BLACK OR BLACK BRITISH**Caribbean African Any other black background **Patient declined** [ ]  |  [ ] [ ] [ ]  |

**PERSONAL HISTORY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Do you have or ever had?:** | **NO****√** | **YES****√** | **If yes, please give date of diagnosis/event?** |  |
| DIABETES? |  |  |  |  |
| HEART ATTACK? |  |  |  |  |
| ANGINA? |  |  |  |  |
| HIGH BLOOD PRESSURE? |  |  |  |  |
| STROKE/TIA/MINI STROKE? |  |  |  |  |
| HIGH CHOLESTEROL? |  |  |  |  |
| GLAUCOMA |  |  |  |  |
| OTHER? Please give details: |

 **P.T.O.**

|  |  |  |
| --- | --- | --- |
| **Do you currently take any medication?** | **Yes** [ ]  **No** [ ]  | If ‘yes’ please enter details below,: (or bring a list of your medicines) |
| **Name of Medication:** |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |  |  |
| --- | --- | --- |
| **Do you have any allergies or have you ever had a reaction to any medication?** | **Yes** [ ]  **No** [ ]  | **If yes, please give details** |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Smoking Status**  | **√** |  |  |
| Never smoked |  |  |  |
| Ex-smoker |  | How many a day did you used to smoke? |  | Date stopped smoking? |  |
| Current smoker |  | How many a day do you smoke? |  |  |  |

|  |  |  |
| --- | --- | --- |
| **Do you drink alcohol?** | **Yes** [ ]  **No** [ ]  | If yes, please complete the questions on the attached pages. |

**FAMILY HISTORY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Does anyone in your family have:** | **NO****√** | **YES****√** | **If yes, who?** | **If yes, at what age did they develop the condition?** |
| DIABETES? |  |  |  |  |
| HEART ATTACK? |  |  |  |  |
| ANGINA? |  |  |  |  |
| HIGH BLOOD PRESSURE? |  |  |  |  |
| STROKE/TIA/MINI STROKE? |  |  |  |  |
| HIGH CHOLESTEROL? |  |  |  |  |
| OTHER? Please give details: |

|  |  |  |
| --- | --- | --- |
| Do you have a **Carer** you wish us to know about? | **Yes** [ ]  **No** [ ]  |  |
| If yes, please give details: |
| Are you a **Carer** yourself? | **Yes** [ ]  **No** [ ]  |  |
|  |
|  |

**Signed: ………………………………………………… Date: ……………………………………..**

**PRINT NAME: ………………………………………..**

**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 | Monthlyor 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 |  |

***(Office Use Only)***

***Scoring:***

**SCORE**

*A total of 5+ indicates increasing or higher risk drinking.*

*An overall total score of 5 or above is AUDIT-C positive.*

***(Office Use Only)***

***Score from AUDIT- C (other side)***

**SCORE**

**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 |  |

***(Office Use Only)***

***Scoring:*** *0 – 7 Lower risk, 8 – 15 Increasing risk,*

**TOTAL = =**

 *16 – 19 Higher risk, 20+ Possible dependence*

*TOTAL Score equals*

*AUDIT C Score (above) +*

*Score of remaining questions*

** **

**Summary Care Record Patient Consent Form**

Having read the above information regarding your choices, please choose **one** of the options below and return the completed form to your GP Practice:

**Yes – I would like a Summary Care Record**

□ Express consent for medication, allergies and adverse reactions only.

**or**

□ Express consent for medication, allergies, adverse reactions and additional information.

**No – I would not like a Summary Care Record**

□ Express dissent for Summary Care Record (opt out).

Name of Patient: ………………………………………………..…....................................................................

Date of Birth: ………………………………………… Patient’s Postcode: ……………………………………..…….…….

Surgery Name: ………………………………………. Surgery Location (Town): ………...........................…….

NHS Number (if known): …………………………..………………...............................................................

Signature: ………………………………………………………….. Date: …………………………………………………….……

If you are filling out this form on behalf of another person, please ensure that you fill out their details above; you sign the form above and provide your details below:

Name: …………...............................................................................................................................

**Please circle one:** Parent Legal Guardian Lasting power of attorney

for health and welfare

If you require any more information, please visit http://systems.digital.nhs.uk/scr/patients or phone NHS Digital on 0300 303 5678 or speak to your GP Practice.

**For GP practice use only**

|  |  |  |
| --- | --- | --- |
| To update the patient’s consent status use the SCR consent preference dialogue box and select the relevant option or add the appropriate read code from the options below;  |  |  |
|  |   |  |

|  |  |  |
| --- | --- | --- |
| **Summary Care Record Consent Preference** | **Read 2** | **CTV3** |
| The patient wants a core Summary Care Record (Express consent for medication, allergies and adverse reactions only) | 9Ndm | XaXbY |
| The patient wants a Summary Care Record with core and additional information (Express consent for medication, allergies, adverse reactions and additional information) | 9Ndn | XaXbZ |
| The patient does not want to have a Summary Care Record (Express dissent for Summary Care Record (opt out) | 9Ndo | XaXj6 |