Wyre Forest Health Partnership

York House Medical Centre
York House Medical Centre, Stourport-on-Severn, Worcestershire, DY13 9EH
Phone: 01299 827 171 Fax: 01299 872868

New Patient Questionnaire

WELCOME TO OUR PRACTICE

First Name		**Last Name**	
Address		**Date of Birth**	
Post code		**Place of Birth**	
Tel: Home		**Tel: Mobile**	
Marital Status		**Main spoken language**	
Gender	☐ **Male** ☐ **Female**	**Occupation**	
E-mail		**Next of Kin Name**	
Next of Kin Tel		**Relationship**	
Ethnic origin:	White British/Other white background/ White & Asian/Indian/Pakistani/ Other mixed/Other Asian background/ Caribbean/African/Chinese/ Other black background/Other/Refuse to disclose		

Do you consent to us contacting you by text and/or e-mail?
☐ **Yes** by text and e-mail ☐ **Yes** by text only ☐ **Yes** by e-mail only ☐ **No**

Any email address and/or mobile number given for a person over the age of 14 years must be the person's own details and not those of their parent/guardian.

Under the Data Protection Act we have to inform you that the contents of any e-mails will not be confidential and secure. Any information we obtain from you will be used only for us to communicate with you. This information will not be passed on to any third party and will not be kept for longer than necessary. Confidentiality and security cannot be guaranteed whilst in transit and all e-mails should contain the minimum of identifiable information. Any e-mails you send will be stored on your e-mail provider's server and should be deleted as soon as possible as the NHS have no control over these mail servers.

PLEASE NOTE: YOU CAN VIEW OUR PRIVACY NOTICE ON OUR WEBSITE: www.wyreforesthealthpartnership.co.uk.

Are you a Carer?	☐ **Yes** ☐ **No**	If **Yes** for whom?	
Are you being Cared for?	☐ **Yes** ☐ **No**	If **Yes** by whom?	

If you are a Carer have you completed a yellow carer card to help us identify your needs? ☐ **Yes** ☐ **No**

Have you received information on the Summary Care Record? (SCR is where your basic medical history is shared with hospitals across England in case of an Emergency)	☐ **Yes** ☐ **No**
Do you wish to opt out? (i.e. not let any information about you be available to hospitals, A&E or Out of Hours, if needed)	☐ **Yes** ☐ **No**

Do you Smoke? ☐ **Yes** ❑ **No: Stopped (date):** ❑ **Never**

If Yes - Cigarettes/Cigar/Pipe/E-Cigarette **How many a week?**

Do you exercise? ☐ **Yes** ☐ **No** (If **YES**, please give details)

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Do you drink Alcohol? ☐ **Yes** ☐ **No**

If YES: how many Units a week?

Questions	0	1	2	3	4	Your score
How often do you have a drink that contains alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Height :	**Weight :**
Have you got a recent Blood Pressure Readings? (If YES, please give details below) / **Date:** (approx)	
Have you had any serious illness or operation in the past? Please give details:	
Do you take any regular medications? ☐ **Yes** ☐ **No** (If **YES**, please attach copy of your repeat prescription request form)	

Note: If you have nominated a specific pharmacy for your prescriptions you may need to change this to a more local pharmacy.

Do you have any allergies to any drugs, food or other substances? ☐ **Yes** ☐ **No** (If **YES**, please give details)

❑ I need to carry an adrenaline pen

Have you, your parents, siblings suffered with any of the following (and if so who and at what age)?

Asthma/COPD		Heart Attack/Heart Disease	
Mini Stroke/Stroke/TIA		Epilepsy	
High Blood Pressure		Diabetes	
Glaucoma		Cancer	
Kidney Disease		Depression/Mental Health problems	
Learning Difficulties		Thyroid problems	
Osteoporosis		Atrial Fibrillation	
Dementia		Other	

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Are you currently under Hospital Care?

Hospital Name Consultant

Nature of Problem

Vaccination History please tick if performed and give dates of most recent

❑ Pneumonia ❑ Polio
❑ Tetanus ❑ Flu
❑ German Measles ❑ Shingles ❑Any Other

Have you made an Advance Directive/Living Will? ❑ Yes (please provide copy) ❑ No

WOMEN ONLY

When was your last cervical smear? Date: Result:	**Have you signed a Smear Disclaimer Form?** ❑ Yes **Date signed:**	**Are you in need of contraception?** ❑ Yes ❑ No
Are you on HRT? ❑ Yes ❑ No		**Do you have a ring pessary?** ❑ Yes ❑ No

Do you have a Coil or Implant? ❑ Yes ❑ No If **Yes** when was it fitted?

Special Needs
Detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action

Please state any Sensory Impairment you have (i.e. Speech, Hearing, Sight):

Are you an 'Assistance Dog' User?

Please state any Religious or Cultural needs:

Do you require the help of a Translator / Interpreter?

New patients or temporary registrations will **not be** accepted without proof of identification and proof of address.
You will need bring 1 **PHOTOGRAPH ID AND 1 UTILITY BILL SHOWING CURRENT ADDRESS** to complete the registration process.

This information will only be used by doctors and staff of the Medical Centre and will be treated with confidentiality.

Name____ **Date**________________

For office use only

Two forms of identity seen? 1]
2]

Checked by:
Please inform the patient of their named GP and record it here