Chilwell Valley and Meadows Practice

The Valley Surgery
81 Bramcote Lane
Chilwell
Nottingham NG9 4ET
Telephone: 0115 9430530
Fax: 0115 9431958

Chilwell Meadows Surgery
Ranson Road
Chilwell
Nottingham NG9 6DX
Telephone: 0115 9462767
Fax: 0115 9462977

NEW PATIENT HEALTH QUESTIONNAIRE

Welcome to Chilwell Valley and Meadows Surgery. Your records may take some time to arrive from your previous doctor, and it would help us if you would answer the following questions.

We aim to help you keep fit and well whilst you are with us.

THE DOCTORS AND THE PRACTICE NURSE WILL TREAT ALL INFORMATION YOU GIVE US IN THIS QUESTIONNAIRE AS STRICTLY CONFIDENTIAL

PERSONAL DETAILS:

Full Name and Title	
How do you prefer to be addressed e.g. 'Bob' instead of 'Robert'?	
Date of Birth	
Occupation/school attended (under 18s)	
Home Telephone Number	
Work Telephone Number	
Mobile number	
Email address	
	Giving us your mobile phone number and/or email address provides consent for us to contact you about issues related to your personal health. We will not pass your details on to anyone else. You can opt out at any time. Please let us know.
Main Language Spoken	
Ethnicity	I would/would not like my ethnic group to be recorded on my records **(delete as appropriate)** Ethnic group:

Do you have a need for information/communication in alternative formats? E.g. large print	Detail:
Next of kin contact details	Name: …… Phone number: …… Relationship to you: …… Contact in emergency: Y/N

Does anybody have **Lasting Power of Attorney** for you? **Y/N**, if Yes is it for (tick as appropriate):	a) Property/finance b) Health/welfare
If yes above, can we have a copy for our records. PLEASE BRING THIS IN. Who holds the lasting power of attorney:	Details:

MEDICAL HISTORY: Have you ever suffered from any of the following medical problems? Please tick where appropriate

Arthritis	Asthma
Cancer	Chronic Bronchitis
Depression	Heart Attack/Angina
Diabetes	Thyroid trouble
High Blood Pressure	Tuberculosis
Ulcer (duodenal or gastric)	Hysterectomy
Glaucoma	Other Illness

When was your last Tetanus ……..
When was your last Polio……..

Height:	Weight:

What operations have you had?

Are you on any medicines/inhalers?

Are you allergic to anything, especially drugs/medications?

Did either of your parents die of heart disease?
Do any illnesses or diseases run in your family (parents, brothers, sisters etc)?
Have you ever smoked on a regular basis? Yes…… No…… If yes, for how many years have you smoked?…… If you smoke cigarettes, how many in a day?…… **BE HONEST** If no, have you ever smoked?……
How much alcohol do you drink in a week?
How do you keep fit?
Are you a Carer? Y/N (Please ask at reception for a leaflet) Do you have a Carer? Y/N (please ask at Reception for a contact details form)
Are you living in a household with someone in the military? Y/N
Is there anything about your health that you wish to discuss with us?
FOR WOMEN ONLY
When was your last cervical smear?
Do you check your breasts in mid-cycle?

For office use: **Photo ID seen** ☐ **Proof of address seen:** ☐

FAST alcohol questionnaire

Here are the four questions on the FAST test:

1. How often do you have eight or more drinks on one occasion?

__ Never __ Less Than Monthly __ Monthly __ Weekly __ Daily or Almost Daily

2. 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

3. How often during the last year have you failed to do what was normally expected of you because of your drinking?

__ Never __ Less Than Monthly __ Monthly __ Weekly __ Daily or Almost Daily

4. Has a relative or friend, a doctor or other health worker been concerned about your drinking or suggested you cut down?

__ No __ Yes, but not in the last year. __ Yes in the last year.

How to Score the FAST Test

To score the FAST test, use the following guide to scoring questions 1, 2 and 3:

- Never: 0 points
- Less than monthly:1 point
- Monthly: 2 points
- Weekly: 3 points
- Daily or almost daily: 4 points

To score question 4 use the guide below:

- No: 0 points
- Yes, but not in the last year: 2 points
- Yes, in the last year: 4 points

NHS Family doctor services registration

GMS1

Patient's details

Please complete in BLOCK CAPITALS and tick ☑ as appropriate

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname

Date of birth

First names

NHS No.

Previous surname/s

☐ Male ☐ Female

Town and country of birth

Home address

Postcode

Telephone number

Please help us trace your previous medical records by providing the following information

Your previous address in UK

Name of previous doctor while at that address

Address of previous doctor

If you are from abroad

Your first UK address where registered with a GP

If previously resident in UK, date of leaving

Date you first came to live in UK

If you are returning from the Armed Forces

Address before enlisting

Service or Personnel number

Enlistment date

If you are registering a child under 5

☐ I wish the child above to be registered with the doctor named overleaf for Child Health Surveillance

If you need your doctor to dispense medicines and appliances*

**Not all doctors are authorised to dispense medicines*

☐ I live more than 1 mile in a straight line from the nearest chemist

☐ I would have serious difficulty in getting them from a chemist

☐ Signature of Patient ☐ Signature on behalf of patient Date

Please see overleaf re: Organ donation

Family doctor services registration

GMS1

NHSOrgan Donor registration

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death. Please tick as appropriate

☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

Signature confirming consent to organ donation **Date**

For more information, please ask for the leaflet on joining the NHS Organ Donor Register

NHSBlood Donor registration

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.

Tick here if you have given blood in the last 3 years ☐

Signature confirming consent to inclusion on the NHS Blood Donor Register **Date**

For more information, please ask for the leaflet on joining the NHS Blood Donor Register
My preferred address for donation is: (only if different from above, e.g. your place of work)

Postcode:

To be completed by the doctor

Doctors Name HA Code

☐ I have accepted this patient for general medical services
☐ For the provision of contraceptive services
☐ I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice

Doctors Name, *if different from above* HA Code

☐ I am on the HA CHSlist and will provide Child Health Surveillance to this patient **or**

☐ I have accepted this patient on behalf of the doctor named below, who is a member of this practice and is on the HA CHS list and will provide Child Health Surveillance to this patient.

Doctors Name, *if different from above* HA Code

☐ I will dispense medicines/appliances to this patient subject to Health Authority's Approval

☐ I am claiming rural practice payment for this patient.
Distance in miles between my patient's home address and my main surgery is

I declare to the best of my belief this information is correct and I claim the appropriate payment as set out in the Statement of Fees and Allowances. An audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission.

Authorised Signature

Name Date

Practice Stamp

HA use only Patient registered for ☐ GMS ☐ CHS ☐ Dispensing ☐ Rural Practice

Printed by THE ASTRON GROUP, 03/02, J0160463