Highgrove Surgery New Patient Questionnaire

It may be several weeks before we receive your medical records from your previous GP. Please try and complete this questionnaire in full to give us any important information about your health. All information will be kept strictly confidential.

CONTACT DETAILS

Title: First Name: Last Name:

Date of Birth: Country of Birth: NHS number:

Address:

Next of Kin name: Relationship to you: Next of kin contact number:

In case of a child the next of kin would be the carer of the child

Tel no: (Mobile) (Home) (Work) (Preferred number)

Would you like us to send a text message with appointment confirmations and occasional medical information relevant to your condition? (Test results, medical recommendations) (Please note this text would never have identifiable details of you but may contain information about your medical condition or recent test results) *Yes* ☐ / *No* ☐

Email Address

What is the best way to communicate with you: letter ☐, text message ☐, Email ☐

To verify your mobile and email address, we may send you a verification message, please respond to it

Are you: - Employed ☐ /Unemployed ☐ /Studying ☐ /Retired ☐ /Full time parent ☐

Occupation:

Are you a carer? *Yes* ☐ */No* ☐ Who for Relationship Tel no

Do you have a carer? *Yes* ☐ */No* ☐ Name Relationship Tel no

ETHNICITY

Please circle the ethnic group which most closely matches your ethnicity.

(Asian or Asian British) Bangladeshi ☐
(Asian or Asian British) Indian ☐
(Asian or Asian British) Other ☐
(Asian or Asian British) Pakistani ☐
(Black or Black British) African ☐
(Black or Black British) Caribbean ☐
(Black or Black British) Other ☐
(Mixed) Other ☐
(Mixed) White and Asian ☐
(Mixed) White and Black African
(Mixed) White and Black Caribbean
(Other) Chinese
(White) British ☐
(White) Irish ☐
(White) Other ☐

Other ethnicity please specify

Main Spoken Language: Do you speak English? YES ☐ / NO ☐

If you have difficulty communicating in English, we do strongly recommend you provide us with somebody that can help translating. This would make phone consultations possible, speed up appointments offered and future contact/reviews.

RELIGION

Please circle the ethnic group which most closely matches your ethnicity. This information is used to plan provision of our services e.g. advocacy services.

Catholic ☐ Jewish ☐ Hindu ☐ Buddhist ☐
C of E ☐ Muslim ☐ Sikh ☐ No religion ☐
Other Christian (state): Other religion (state):

MEDICAL HISTORY

Have you been diagnosed with any of the following?

Diabetes ☐ Asthma ☐ High Blood Pressure ☐ Chronic bronchitis ☐ Gastritis ☐

Heart Disease ☐ High Cholesterol ☐ Stroke ☐ Epilepsy ☐ Rheumatoid arthritis ☐

Please complete form bellow if you have had any of the conditions above or any other major conditions

Condition	Year diagnosis	Treatment

Any major previous surgeries?, please complete form bellow

Surgery	Year	Any current problems

FAMILY HISTORY

Has anyone in your immediate family had any of the following?

High Blood Pressure ☐ High Cholesterol ☐ Diabetes type 2 ☐

Asthma ☐ Heart Disease ☐ Stroke ☐

Breast cancer ☐ Bowel cancer ☐

WOMEN ONLY

When was your last smear Where was it taken Result

Have you ever had an abnormal smear Yes ☐ / No ☐ Date Result

Were you treated in the colposcopy clinic? Yes ☐ / No ☐

BLOOD TESTS

When was your last blood test and reason?

Are you due any blood tests?

MEDICATIONS

Do you take any regular medication? *Yes* ☐ / *No* ☐

By giving us the name and dose may facilitate issuing you a prescription before your records arrive

Name	Dose	Frequency	Reason

Are you allergic to any medication? *Yes* ☐ / *No* ☐ Which ones?

SMOKING

Do you smoke? *Yes* ☐ / *No* ☐ If Yes how many per day:

Ex-Smoker? Yes ☐ /No ☐ How many years did you smoke for? Average of cigarettes per day

ALCOHOL

How often do you have a drink that contains alcohol: Never ☐ Monthly ☐ 2-4 times week ☐ 4 + week ☐

Recent Measurements: please state dates.

Weight Height

Blood Pressure Pulse

HOW MUCH EXERSICE DO YOU TAKE

None ☐ Walking less than 30 minutes per day
Light ☐ Walking 30-60 minutes per day
Moderate ☐ Cycling / swimming / tennis 3x/week
Heavy ☐ Running, gym aerobics, football more than 3 hours per week

Patient Participation Group

The practice is committed to improving the services we provide to our patients.
To do this, it is vital we hear from people about their experiences, views and ideas for making services better.
By expressing your interest, you will be helping us to plan ways of involving patients. It will also mean we can keep you informed of opportunities to provide your views and update you of any changes / developments within the practice.
If you are interested in getting involved, please tick the box below and we will arrange for the Practice Patient Participation Group Application Form to be sent to you via email.

Yes, I am interested in becoming involved in the Practice Patient Participation Group ☐

Online Access

Would you like to register for online booking of appointments and repeat medication? (Please note you will need an email address in order to be able to use this). Only available to patients 16 and over.

☐ Yes, I am interested in registering for online booking of appointments and repeat medication and provide your email address.

Please note: Your Username and Password can be sent to you via text, so please ensure we have a mobile contact number for you.

Any other comments?

It is very important you keep your details up to date, any change notify us as soon as possible, especially for contact details
We are committed to try to help you to the best of our possibilities, we expect the same from you.
We do not accept any kind of abusive/offensive behaviour.
Thank you for completing this form

For more information about the services we offer, please see the practice website:
www.highgrovesurgery.nhs.uk
You can email this form with other required documents to:
highgrovesurgery@nhs.net
