Danby Surgery **Your Named GP will be .....**

New Patient Check Appt ..... EMIS No:.....

'NEW PATIENT HEALTH QUESTIONNAIRE

Surname: ..... **Forename(s):** .....

Date of Birth: ..... **Mobile Number**: .....

Email address: .....

You will be automatically registered to receive messages by email, mobile phone & SMS text message. If you would like to opt out please inform reception. It is your responsibility to let the practice know if you have a change in phone number or email address.

If you are of school age, are you home schooled? YES / NO

Do you have any information and / or communication support needs e.g. interpreter, information or letters in larger type or use braille. YES NO (delete as appropriate)

If "Yes" please let us know what support you need

.....

.....

Occupation: .....

EX-ARMED FORCES PERSONNEL AND VETERANS

Have you ever served in the armed forces Yes/No

If YES which of the armed forces did you serve and when did your time in service cease?

.....

SMOKING

Do you smoke? Yes / No

If Yes, how many:
Cigarettes per day ..... Cigars per day ..... Ounces of tobacco per day .....
How old were you when you started smoking? .....
Would you like help in stopping smoking? Yes / No

EX-SMOKERS

How old were you when you stopped smoking? .....

How much did you smoke per day? .....

PASSIVE SMOKING

Are you exposed to smoke at work? Yes / No At home? Yes / No

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ALCOHOL

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

TOTAL 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	

Scoring: 0–7 Lower risk, 8–15 Increasing risk, 16–19 Higher risk, 20+ Possible dependence

TOTAL SCORE: .....

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EXERCISE
Do you take regular exercise? Yes / No
If yes, what sort of exercise? ……
How many times per week? ……..

FAMILY HISTORY
Is there any of the following in your family *(father, mother, brother, sister)* before age of 65?
Heart Disease (heart attacks, angina) Yes / No Which family member? ……
Stroke? Yes / No Which family member? ……
Cancer? Yes / No Which family member? ……
Site of cancer? ……

ALLERGIES

Are you allergic to any substances or foods? Yes / No

If yes, please give details:
……

……

Weight (approx): …….. **Height**: ……

CARERS

Do you need / have anyone who looks after you or your daily needs as Carer? Yes / No
What is the name of your carer?.....
If "Yes", would you like them to deal with your health affairs here? Yes / No
(reception can help you with this)

Do you care for anyone else? Yes / No
What is the name of the person you care for?.....
If "Yes", ask the receptionist about Carers support

Are you housebound? Yes / No

PATIENT PARTICIPATION GROUP
Would you like to join Danby Surgery Patient Participation Group Yes / No

If YES would you like to attend meetings or be on the virtual group and only be contacted by email

……

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PATIENT ETHNIC ORIGIN QUESTIONNAIRE

This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act. Please indicate 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 some of these conditions.

Choose ONE section from A to E, and then tick ONE box to indicate your background.

A White

	British
	Irish
	Any other white background please write in below

B Mixed

	White and Black Caribbean
	White and Black African
	White and Asian
	Any other mixed background please write below

C Asian or Asian British

	Indian
	Pakistani
	Bangladeshi
	Any other Asian background please write below

D Black or Black British

	Caribbean
	African
	Any other black background please write below

E Chinese or other ethnic group

	Chinese
	Any other please write below

Declined	

First language

Thank you for completing this questionnaire.

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Information for new patients: about your Summary Care Record

Dear Patient,

If you are registered with a GP practice in England you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. You may need to be treated by health and care professionals that do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs.

Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

You have a choice

You have the choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care.

Your options are outlined below; please indicate your choice on the form overleaf.

- **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies for adverse reactions only.

- **Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies for adverse reactions and further medical information that includes: Your illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.

- **Express dissent for Summary Care Record (opt out).** Select this option, if you **DO NOT** want any information shared with other healthcare professionals involved in your care.

If you chose not to complete this consent form, a core Summary Care Record (SCR) **will** be created for you, which will contain only medications, allergies and adverse reactions.

Once you have completed the consent form, please return it to your GP practice.

You are free to change your decision at any time by informing your GP practice.

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Summary Care Record Patient Consent Form

Having read the above information regarding your choices, please choose one of the options below:

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: Danby Surgery Surgery Location: Briar Hill, Danby, Whitby, North Yorkshire, YO21 2PA
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.

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CARE DATA

TYPE 1 - OPT-OUT FROM PERSONAL CARE DATA LEAVING PRACTICE

If you do not want personal identifiable data leaving the practice for purposes beyond your individual care. Please tick the appropriate box and complete your personal details, remembering to sign and date before handing into reception.

□I object to my personal identifiable data leaving the practice for purposes beyond those required for my individual care.

□ I authorise the practice to add the dissent code (declines secondary use of GP patient identifiable data code 9Nu0) to my medical record.

Name

Address

Date of Birth

Signature Date

TYPE 2 – OPT-OUT FROM PERSONAL DATA USED FOR RESEARCH AND PLANNING

Please see the enclosed leaflet Your Data Matters to the NHS which includes detailed information and details of how to opt-out if you wish to do so.