APPLEBY MEDICAL PRACTICE

New Patient Questionnaire (16yrs and over)

To register with the Practice please complete this questionnaire as fully as possible. The information will help the practice to provide better medical care for you. This information will be held in the strictest confidence as per Data Protection.

Please bring photographic ID and verification of current address with you when you register.

Date form completed		Informed of Named GP	

Surname		Forename(s)	
Maiden Name			
Date of Birth		Marital status	
Address and Postcode			
Home Number		Mobile	
Email address			
Main language spoken			
Which of the following options best describes how you think of yourself?		Female / Male / Non-binary / other (please state):	
Is your gender identity the same as the one you were given at birth?		Yes ☐ No ☐	
Do you have any hearing difficulties		Yes ☐ No ☐	
If you have supplied your mobile number, please confirm if you would be happy to receive contact from the surgery via text i.e appointment reminders		Yes ☐ No ☐	
Do you consent to being contacted via:		Phone☐ / Mobile☐ / Email ☐	

Diet	
Do you add salt to your food after cooking?	Yes ☐ No ☐
Do you have a varied diet including milk, meat, vegetables and fruit?	Yes ☐ No ☐
Has your Cholesterol been checked in the last 2 years?	Yes ☐ No ☐

Exercise	
Do you take regular exercise?	Yes ☐ No ☐
If yes, what sort of exercise?	
How many times per week?	

Family History – (brothers, sisters, parents, uncles, aunts, grandparents)		
Heart Disease (heart attacks, angina)	Yes ☐ No ☐	Which family member?
Stroke?	Yes ☐ No ☐	Which family member?
Cancer?	Yes ☐ No ☐ Site of cancer?	Which family member?

Allergies	
Are you allergic to any substances or foods?	Yes ☐ No ☐
If yes, please give details:	

Medication

Please give details of any medication which you take (prescribed or otherwise). It would be helpful if you could provide the surgery with proof of medication so that they can be added to your record, eg. Summary print-out from previous GP or the right hand side of your prescription with items listed.

	Name of drug	Dosage
1		
2		
3		

Pharmacy of Choice

Please advise the Pharmacy you would like us to issue your medication to :

If we believe that you are eligible for the Practice Repeat Dispensing Programme, please advise if you would like us to action	Yes ☐ No ☐

Past Medical History
Please give details of any hospital treatment as an in-patient:
Please give details of any treatment for any chronic medical conditions:
Please give dates of any X-ray, MRI or CT scans, Mammogram, Ultrasound:

Female Patients	
Date of most recent cervical smear:	
Result of most recent smear:	
Please give details of any complications in pregnancy:	
Do you use any form of contraception	Pill ☐ Injection ☐ Implant ☐ Coil ☐

Social History	
Do you live alone	Yes ☐ No ☐
Are you Homeless	Yes ☐ No ☐
Do you have a Social Worker	Yes ☐ No ☐
Have you suffered or are you currently suffering domestic abuse? (including coercive control, financial, verbal, physical, sexual or emotional abuse)	Yes ☐ No ☐
If yes, do you require any support around this?	Yes ☐ No ☐
If "Yes", would you like them to deal with your health affairs here?	Yes ☐ No ☐

Disability, Age Related Problems or Special Needs Do you have any problems with			
Vision	Yes ☐ No ☐	**Speech**	Yes ☐ No ☐
Mobility	Yes ☐ No ☐	**Hearing**	Yes ☐ No ☐
Learning Difficulties	Yes ☐ No ☐	**Autism**	Yes ☐ No ☐
Reasonable Adjustments Do you need any help to see the nurse or doctor? – e.g. appointment at a quieter time? Please detail below			

Consent for Third Party Access	
If you would like a family member or friend to be able to discuss your medical records on your behalf? Due to patient confidentiality we need your permission to do this so we can record consent onto your records.	Yes ☐ No ☐
If yes what is their name?	
Relationship to you?	

Application for online access to my medical record	
I wish to have access to the online services – Booking Appointments, Ordering Medication, viewing my Medical Records	Yes ☐ No ☐
I will be responsible for the security of the information that I see or download	Yes ☐ No ☐
If I choose to share my information with anyone else, this is at my own risk	Yes ☐ No ☐
I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	Yes ☐ No ☐
If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	Yes ☐ No ☐
The access information will be sent to you following your registration to the Practice.	

Please Complete	
Signature	**Date**

If this information cannot be provided, you may be registered as a Temporary Patients until above details provided.

Thank you for completing this questionnaire.

For practice use only

Patient NHS number		Practice computer ID number
Identity verified by (initials)	Date	Method Vouching ☐ Vouching with information in record ☐ Photo ID and proof of residence ☐
Authorised by		Date