For staff purposes only:
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Eastgate Surgery

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New Patient Questionnaire.

To our new patients aged between 40-75, we recommend you attend for an NHS Health Check. This will be arranged after successful registration at the practice.

For Staff purposes only	
Form checked by:	Date (please stamp):
ID seen (please tick): YES NO	Name of staff member:

PLEASE COMPLETE THIS FORM CLEARLY, IN BLOCK CAPITALS AND IN BLACK INK.

Personal information.

Title					
Full Name					
Date of Birth					
NHS Number					
Address					
Post code					
Mobile number					
Landline number					
Town and Country of birth					
If born outside of the UK, please state the date you entered the country					
Are you a carer? (Please tick)	Yes	No	Who for?		
Have you ever served in the British Armed Forces? (please tick)			Yes		No
Next of Kin details					
1 Next of Kin Name/ relationship					
Next of Kin contact number					
Next of Kin address and postcode					
2 Next of Kin Name/ relationship					
Next of kin contact number					
Next of kin address and postcode					

Monitoring information.

Effective monitoring is a requirement for the NHS as part of the Equality Act 2010. Patients are asked to provide their data on a voluntary basis, it is stored anonymously and used confidentially, it is not used to identify anyone. We encourage everyone to provide this information. Collecting and analysing equality information is an important way for us to develop this understanding to help us identify what we need to change to improve our services to patients.

Which of the following options best describes how you think of yourself? (please tick)				
Woman (including trans woman)	Man (including trans man)	Non- binary	In another way	Prefer not to say
Is your gender identity the same as the gender you were assigned at birth? (please tick)			Yes	No
Prefer not to say				
Which of the following options best describes how you think of yourself? (please tick)				
Straight/ Heterosexual	Bisexual	Gay	Lesbian	
Prefer not to say				
If other, please specify				

Ethnicity				
White (please tick)	English	Scottish	Welsh	European
Asian (please tick)	Asian British	Indian	Bangladeshi	Pakistan
Black (please tick)	Black British	Caribbean	African	
Other (please specify your ethnicity if not listed above)				

Religion (please tick)						
Christian	Hindu	Jewish	Buddhist	Muslim	Atheist	Other
If other, please specify						

Health Questions.

Do you have any allergies?	Yes	No
If yes, please state your allergy:		
Are you a current smoker?	Yes	No
If yes, how many a day?		
Are you an ex- smoker?	Yes	No
If yes, what date did you quit?		
What is your height?		
What is your weight?		
Do you have any disabilities or special needs? This includes visual or hearing impairments.	Yes	No

If yes, please specify					
For Female patients or those who have a cervix, when was your last cervical screening?					
For the following questions, please tick the answer that best For reference, 1 drink (unit) = half a pint of beer/ lager OR 1 glass of wine or 1 single spirit.					
How often do you have a beverage containing alcohol? Please tick					
Never	Less than monthly	Monthly	Weekly	Daily	Almost daily
How many units of alcohol do you drink on a typical day when you're drinking? Please tick					
1-2	3-4	5-6	7-8	10+	
How often have you had 6 or more units if you're female OR 8 of more units if you're male on a single occasion in the last year? Please tick					
Never	Less than monthly	Monthly	Weekly	Daily	Almost daily

Please provide a brief summary of your personal medical history:

Year	Details

Do you have a family history of?

Condition	Y/N	Which family member
Heart disease		
Diabetes		
Cancer		
High blood pressure		
Cholesterol		
Stroke		
Asthma		

Current Medication:

Please provide a current list of your medications. This can be obtained from your previous surgery.

Doctor Patient Agreement.

In order to register at Eastgate Surgery, you will need to read the practice's doctor/ patient agreement below. You will then need sign at the end of the document to state that you have both read and understood this document and agree to adhere to our guidelines.

♦ Appointments are made for one person at a time. Please do not bring any other individual to see the GP unless they have their own booked appointment.
♦ Should you present to a GP with more than one issue (unless stated and documented beforehand) your GP may ask you to make another appointment to discuss these issues.
♦ If you no longer need an appointment, please try to cancel it at least 24 hours prior to the appointment.
♦ Patients who fail to attend more than 3 appointments with a clinician may be deducted from our patient list.
♦ Patients who make inappropriate use of emergency services when the surgery is closed will be removed from the patient list.
♦ Any complaints or suggestions should be put in writing to the practice manager.
♦ We have a zero-tolerance policy against rule and aggressive behaviour towards all members of staff. You will be removed from the list should you act in this way towards staff.
♦ If you are unable to make your appointment on time, please notify the surgery as soon as possible so arrangements can be made.
Signed
Dated

Record Sharing.

An informed patient, in consultation with a Health Care Department Care Professional, can choose to permit or restrict access to the information entered into their records at each System One organisation that accesses their record. The patient will be asked to give their record sharing consent at each organisation at which they receive care. The patient's consent can be changed at any time.		
Sharing out		
Does the patient consent to the sharing of data recorded here with any other organisation that may care for the patients that use System One? Please tick	Yes- share data with other organisations	No- do not share any recorded data here
Sharing in		
Does the patient consent to the viewing of data by this organisation that is recorded at other care services that may care for the patient that use System One where the patient has agreed to make the data shareable?	Consent given	Consent refused
Signed		
Full name		
Date		

Application for online access to patient medical records.

Full Name	
Date of birth	
Full address	
Email address	
Telephone number	

I wish to have access to the following online services (please tick all that apply)

Appointment booking	Repeat prescription ordering	Accessing my medical record

I wish to have access to my medical record and understand and agree with each statement below (please tick all that apply and sign you have understood)

1. I will be responsible for the security of the information that I access or download	
2. If I choose to share my information with any other individual, that is at my own risk	
3. If I suspect that my account has been accessed by someone without my prior consent, I will contact Eastgate Surgery as soon as possible	
4. If I see information in my record that is inaccurate or not about me, I will contact the practice as soon as I can	
5. If I think that I may come under pressure to give an individual access to my account, I will contact the practice as soon as possible.	

Signature of patient	
Date	

Consent nomination form.

Would you like to nominate other individual (s) to speak on your behalf? If so, please complete the tables below. This individual will then be able to book appointments, receive test results and communicate with practice staff about anything on your behalf.

If you **would not** like to nominate another individual, please leave this blank.

If you feel pressured to fill this page out or would like to discuss this with a member of the practice team, please ask to speak to the Office Manager or Quality Assurance Manager when you hand these forms into the practice.

Name of individual	
Contact Number	
Are they a patient of the practice? Please tick.	Yes ☐ No ☐

Name of individual	
Contact Number	
Are they a patient of the practice? Please tick.	Yes ☐ No ☐

I give formal consent for the individual (s) named above to speak on my behalf regarding any aspect of my care:
Signature:
Printed name:
Date:

Patients can withdraw consent at any time.