ALTRINCHAM MEDICAL PRACTICE

Data Protection Act New patient Questionnaire– Appendix 1 to Annex M

We need some information about you as soon as you register, as your medical records may take several weeks to arrive. Please answer each question as fully as you can circling one answer only where there's a choice. If you need any help filling in this sheet, please just ask one of our staff. This confidential information will be stored on our computer system and used only for healthcare purposes.

How We Handle Our Patients' Personal Data

The Practice is required to process patients, personal and special category data, in various situations including; detailed information on how and why we do this is contained within Annexes A and F to this document; and can be found at www.altrinchammedicalpractice.co.uk or ask the Reception staff for a copy.

Date you completed this form: ______________

For office use only:
ID checked: _____
Address checked: _____
Repeat Rx info: _____

YOUR DETAILS

Surname: ____________________ Forenames: ________________________

D.O.B:____________ Title:_____ Any previous surnames: ______________

NHS Number (If Known) _________________________:

Telephone no's (**including mobile**): _________________________________

Email Address: ……………………………………….

By giving us your mobile telephone number and/or email you are consenting to allow us to use this to send you text messages and emails about your care and the surgery

Profession:…………………………………………..

First Language (if not English) ________________________

Do you require an interpreter for consultations? YES/NO

Do you have any communication needs? YES/NO

If yes, please indicate if you require communication to be provided in LARGE PRINT/BRAILLE/TEXT MESSAGING/SIGN LANGUAGE/DEAFBLIND MANUAL INTERPRETER/SPEECH TO TEXT REPORTER

Do you have a carer? YES / NO | Contact details ___________________________________

Are you a carer? YES/NO

(ie Are you responsible for the care of another adult/child with a disability)

Information for carers is available www.altrinchammedicalpractice.co.uk or from reception.

Are you permanently housebound? YES/NO

Are you a HM Forces Veteran? YES/NO

What is your Ethnic Group?

The practice has been asked to request this information as part of the Department of Health's commitment to race equality.

This information is not mandatory; however, it could be very important to the practice in assisting in diagnosis and identifying cause and prevalence of conditions which vary according to ethnicity. Please tick one box

- ☐ *White*
- ☐ *White British*
- ☐ *White Irish*
- ☐ *Indian*
- ☐ *Pakistani*
- ☐ *Bangladeshi*
- ☐ *Other Asian Background*

Detail ------------------------------

- ☐ *Black Caribbean*
- ☐ *Black African*
- ☐ *Other Black Background*
- ☐ *Chinese*
- ☐ *Other ethnic Group*

Detail ----------------------------

Do not wish to state Ethnicity ☐

For Women only:

Date of last smear test: ________________ In which city? ____________________

Result: ____________________________

If you use contraception; which form do you use? ___________________________________

YOUR FAMILY HISTORY – if any of your immediate family were diagnosed with any of these illnesses please tell us by ticking the appropriate box(es).

	Mother	Father	Sisters	Brothers
Asthma				
Diabetes				
Stroke/TIA				
Heart Disease				
High Blood Pressure				

YOUR CURRENT STATE OF HEALTH

Do you suffer from any allergies or have you had a reaction to any medication? YES/NO

If yes please give details: ____

Have you ever suffered from? *(Delete as appropriate)*

Epilepsy	Yes/No	Glaucoma	Yes/No
Hypothyroidism	Yes/No	High Blood Pressure	Yes/No
Diabetes	Yes/No	Stroke/TIA	Yes/No
Depression	Yes/No	Mental Health	Yes/No
Cancer	Yes/No	COPD	Yes/No
Asthma	Yes/No	Heart Disease	Yes/No

Please list and date any serious or chronic illnesses, operations or disabilities:

____

DRUGS & MEDICINES

Are you taking any regular prescribed medication? YES/NO

If yes, please attach an up-to-date re-order slip from your last practice so we can review this before you need a further supply. If not available, please write your previous surgery's phone no here: ____

EPS

As of 18/11/15 this Practice will be offering EPS to all of our patients. If you would like to sign up for this service please ask a member of staff for the appropriate forms.

LIFESTYLE HABITS – please circle or complete each section

Smoking Status:

Never smoked tobacco **( )** Ex-smoker **( )** – I gave up in (year) _________
Current Smoker **( ) -** I currently smoke ________/day

If you smoke would you like advice on giving up? YES/NO

ALCOHOL SCREENING TOOL

UNIT GUIDE

1 unit is typically:
Half-pint of regular beer, lager or cider; 1 small glass of low ABV wine (9%); 1 single measure of spirits (25ml)

The following drinks have more than one unit:
A pint of regular beer, lager or cider, a pint of strong /premium beer, lager or cider, 440ml regular can cider/lager, 440ml "super" lager, 250ml glass of wine (12%)

2 3 1.5 2 4 2 9

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 a month	2-3 times a week	4 or more times a week	
How many standard drinks containing alcohol do you have on a typical day when drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10+	
How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
If score 5+ then answer next 7 questions				**TOTAL**		
During the past year, how often 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	
During the past year, how often have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
During the past year, how often have you needed a drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
During the past year, how often have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
During the past 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 someone else been injured as a result of your drinking?	No		Yes, but not in the past year		Yes, during the past year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the past year		Yes, during the past year	

Scoring: 0-7 = sensible drinking, 8-15 = hazardous drinking, 16-19 = harmful drinking and 20+ = possible dependence

Signed ______________________________________ **Date** ____________

Please return to: Altrincham Medical Practice, Lloyd House, 7 Lloyd Street, Altrincham, WA14 2DD