FAIRFAX GROUP PRACTICE
NEW PATIENT QUESTIONNAIRE

You should ensure that all pages of this form are completed and returned to the practice to allow registration. Please also bring ID and proof of address with you.

SECTION 1 - PERSONAL DETAILS

Surname _____

Forename _____

Address _____

_____

Postcode _____

If patient is school age please indicate which school is attended _____

NHS Number _____ Nationality _____

First Language _____ *Do you require an interpreter?* _____

Date Of Birth _____ Place Of Birth _____

Male/Female _____ Telephone No _____

Mobile Number _____ Email Address _____

Are you a military veteran? ☐ Yes ☐ No

Ethnicity

Please select from the following list:

☐ British	☐ Irish	☐ Other White Background
☐ White and Black Caribbean	☐ White and Black African	☐ White and Asian
☐ Any other Mixed Background	☐ Indian	☐ Pakistani
☐ Bangladeshi	☐ Other Asian Background	☐ Caribbean
☐ African	☐ Any other Black Background	☐ Chinese
☐ Any other Ethnic Group	☐ Not Stated	☐ Declined

Sexual Orientation

☐ Heterosexual ☐ Bi-sexual ☐ Lesbian ☐ Gay

☐ I do not wish to declare my sexual orientation

Next of Kin (full name) _____

Relationship to the patient _____

Address

_____

_____

Postcode _____ Telephone No _____

Other household members (including non-family members):

Surname	Forename	Date of Birth	Relationship to Patient

SECTION 2 - PAST MEDICAL HISTORY

Please list any illnesses/operations (please use the additional space at the end of this form if required)

_____

_____

_____

Do you suffer from any of the following (please tick)

☐ Asthma ☐ Diabetes ☐ Thyroid Disease

☐ High Blood Pressure ☐ Epilepsy ☐ Heart Disease

Please list any medication you are taking ad dosage if known (attach previous 'repeat' if applicable)

_____

_____

_____

_____

Allergic to any medication? ☐ Yes ☐ No

If Yes, Please detail the type of medication.

_____

_____

Any other allergies? ☐ Yes ☐ No

If Yes, what are you allergic to?

_____

_____

FOR WOMEN ONLY Please list below dates of any pregnancies and details of children

_____

_____

_____

SECTION 3 – MEDICAL HISTORY UNDER 16's ONLY

Immunisations – please give the date these vaccinations were given)

1st DTP/Polio_____	2nd DTP/Polio _____	3rd DTP/Polio _____
1st Hib _____	2nd Hib _____	3rd Hib _____
1st Men C _____	2nd Men C _____	3rd Men C _____
Booster Hib_____	MMR _____	Pre School _____
Booster MMR _____		

Others (please specify)

Birth Weight and any problems at birth

Any developmental issues?

SECTION 4 - FAMILY HISTORY

Are any of your closest family members affected by any of these conditions (please tick)

☐ Asthma ☐ Diabetes ☐ Glaucoma

☐ Blindness ☐ Tuberculosis ☐ Heart Disease

☐ Infectious Diseases ☐ High Blood Pressure ☐ Stroke

☐ Other (please specify) _____

☐ Cancer (please specify the type of cancer if known)

_____

SECTION 5 – EXERCISE

Please indicate which statement best describes you:

☐ I undertake light exercise ☐ I undertake moderate exercise

☐ I undertake heavy exercise ☐ I avoid even trivial exercise

☐ I find exercise physically impossible

What is your height? _____

What is your weight? _____

Please make ask at Reception if you are overweight and would like help to lose weight.

SECTION 6 - CARER HISTORY

A **carer** is anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support.

Do you have a carer? ☐ Yes ☐ No

Are you a carer? ☐ Yes ☐ No

Who do you care for?

Name _____

Address _____

_____

_____

SECTION 7 - ALCOHOL HISTORY

How often do you drink 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 units (if male), on a single occasion in the last year?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

How often in 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

How often during the last year have you failed to do something that was normally expected from you because of drinking?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily

How often during the last year have you needed a drink in the morning to get yourself going after a heavy drinking session?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily

How often during the last year have you had a feeling ofguilt or remorse after drinking?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily

How often in the last year have you been unable to remember the night before because of drinking?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily

Have you or has somebody else been injured as a result of youdrinking?

☐ No ☐ Yes, but not in the last year ☐ Yes, during the last year

Has a relative or friend, doctor or health professional been concerned about your drinking or suggested you cut down?

☐ No ☐ Yes, but not in the last year ☐ Yes, during the last year

SECTION 8 - SMOKING HISTORY

Please tick

☐ Never smoked ☐ Current smoker ☐ Thinking about stopping ☐ Ex-smoker

If you are an ex-smoker please indicate when you stopped? _____

SECTION 9 – DISABILITY

Do you consider yourself to have a disability?

☐ Yes ☐ No

Please indicate or detail below the disability that applies to you

☐ Physical Disability ☐ Learning Disability ☐ Mental Health

☐ Vision Impairment ☐ Hearing Impairment ☐ Other - *please detail below*

_____

_____

Do you need any assistance from us when contacting or attending the surgery? If Yes, please provide details.

☐ Yes ☐ No

_____

_____

SECTION 7 – HIV SCREENING

HIV rates are increasing in the Greater Manchester area. We are able to offer a simple blood test to check your status and if this is something you would like us to arrange, please tick the box below:

☐ Yes – I would like to have a HIV screening test.

SECTION 10 – SUMMARY CARE RECORD

Please read the enclosed information about the NHS Summary Care Record, and confirm your wishes by ticking one of the options below.

Please be advised that we will create your Summary Care Record following your registration with this practice unless you express a preference otherwise.

If you require further information before confirming your wishes please:

- Call the Health and Social Care Information Centre on 0845 300 6016, or
- Visit www.nhscarerecords.nhs.uk

Please tick only one of the options below to confirm your wishes:

1	I want to have a Summary Care Record	
2	I do not want a Summary Care Record ***(Please complete the opt-out form included in the NHS Summary Care Record information pack and return to reception)***	
3	I don't know whether I want a Summary Care Record and need more time to consider my options (Please complete the enclosed Opt-out Form and return to reception. Your current status will be 'opted-out' until you advise us otherwise)	
4	I have previously opted-out of having a Summary Care Record and this is still my preference (Please complete the enclosed Opt-out Form to reconfirm your wishes)	
5	I have previously opted-out of having a Summary Care Record but I now want to have a	

SECTION 9 – DISABILITY

	Summary Care Record (Please discuss with reception)	

SECTION 10 – PRESCRIPTIONS

The use of electronic prescriptions gives us the ability to send your prescriptions directly to a pharmacy which removes the need for you to come down to the surgery to collect them. If you would like to nominate a pharmacy for this purpose, please indicate your choice of pharmacy below.

_____

SECTION 11 – ONLINE SERVICES

Please indicate your preferred method of communication:

☐ **SMS** ☐ **E-mail** ☐ **Neither**

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

Patient Name:_____ Patient D.O.B: _____

1. Booking appointments	
2. Requesting repeat prescriptions	
3. Summary Care Record	

RECEPTION STAFF – THE BOX BELOW MUST BE COMPLETED FOR ALL PATIENTS NOT JUST PATIENTS REQUESTING ACCESS TO ONLINE SERVICES.

OFFICE USE ONLY - RECEPTION		
Form Received and Checked by:		
Patient NHS number		New Patient Check arranged?
Identity verified by (initials)	Date	Method Vouching Vouching with information in record Photo ID and proof of residence
OFFICE USE ONLY – ADMIN STAFF		
Patient registered by:		Date:
All information coded and entered on medical record by:		