Railway Medical Group

New Patient Questionnaire

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

Title Mr / Mrs / Ms / Miss **Date of birth** .....

Maiden name(s) .....

Address .....

.....

Postcode ..... **Telephone number/s** .....

Email address .....

Current occupation .....

Marital status Single / Married / Widow/Widower / Divorced/Separated / Other

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Please answer the following questions;

1. Do you smoke? Never….. Yes .....Cigarettes/Pipe/Cigars/E-cig If not now, date stopped: ……..

If **yes** how much per day .....

2. AUDIT C please circle your answer;

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 1 unit;
a pint of regular beer, larger or cider, a pint of strong/premium bee, lager or cider, 440ml regular can cider/lager, 440ml "super" lager,250ml glass of wine (12%) or a bottle of wine

Audit – C 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	
					TOTAL	

3. Ethnic group

To which of these groups do you consider you belong: (tick one box only)

White:		*Black or Black British:*		*Ethnic Groups:*	
British	☐	Caribbean	☐	Chinese	☐
Irish	☐	African	☐	Any other Ethnic group	☐
Any other White background	☐	Any other Black background	☐		
Asian or British Asian:		*Mixed:*			
Indian	☐	White and Black Caribbean	☐	*Prefer not to disclose*	☐
Pakistani	☐	White and Black African	☐		
Bangladeshi	☐	White and Asian	☐		
Any other Asian background	☐	Any other Mixed background	☐		

4. Height ..... **Weight** .....

5. Are you a carer? Yes ….. No……

If so, do you consent to us recording this on our system? Yes …. No ……

By providing this information it will enable us to flexibly meet your needs.

6. Do you have any medical problems?

Yes ..... No .....

If **yes** please give details .....

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.....

7. Have you had any other illnesses, accidents or operations in the past?

Yes ..... No .....

If **yes** please give details .....

.....

.....

8. Are you under the care of a hospital consultant at the moment?

Yes ..... No .....

Name of consultant Hospital Diagnosis

.....

.....

9. Do you take any regular medication?

Yes ..... No .....

If **yes** please give details .....

.....

.....

10. Do you have any allergies to medicines or tablets?

Yes ..... No .....

If **yes** please give details .....

.....

11. Female Patients Only

Contraception method: .....

Date of last cervical smear result .....

Date of last breast screening result .....

12. Family History

Please give details of the state of health or cause of death of family members eg. heart attack, stroke, diabetes, hereditary condition or other disease. The relative may alive or dead, please indicate their age now or at death including cause of death or current state of health

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13. Summary Care Record

Did you have a Summary Care Record at your previous doctor's surgery? YES / NO
See enclosed leaflet

Consent for sharing of Summary Care Record (see enclosed leaflet) YES / NO

Consent for sharing of Shared Health Care Record (see enclosed Leaflet) YES/ NO

14. Are you a Military Veteran? YES / NO
Armed forces, regular or reserve, Merchant Navy seafarers and fishermen who served in a vessel which facilitated military operations by armed forces.

If YES can we record this on your medical record? YES / NO

15. Communication Needs

Please inform us if you have any communication needs i.e. Braille, large print etc.
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Signature **Date**

For Office Use Only

For over 75's enter code 9NN60 as Named GP ☐

First spoken language

Patient not willing to give information: ☐

Please tick to indicate:

Akan		Lithuanian	
Albanian		Luganda	
Amharic		Makaton (sign language)	
Arabic		Malyalam	
Bengali		Mandarin	
Brawa		Norwegian	
British signing language		Pashto (Pushtoo)	
Cantonese		Patois	
Croatian		Polish	
Dutch		Portuguese	
English		Punjabi	
Ethiopian		Russian	
Farsi (Persian)		Serbian	
Finnish		Sinhala	
Flemish		Somali	
French		Spanish	
French creole		Swahili	
Gaelic		Swedish	
German		Sylheti	
Greek		Tagalog (Filipino)	
Gujarati		Tamil	
Hakka		Thai	
Hausa		Tigrinya	
Hebrew		Turkish	
Hindi		Urdu	
Igbo (Ibo)		Vietnamese	
Italian		Welsh	
Japanese		Yoruba	
Korean		Other – please specify below:	
Kurdish			
Lingala			

Pharmacy nomination for prescriptions

Our practice is now moving to an electronic prescribing system (EPS) which means that when your prescription is authorised by the GP it will automatically be sent to the chemist electronically. By nominating a dedicated pharmacy you will not need to pick your repeat prescriptions up from the surgery and then take them to a pharmacy, you will be able to go straight to your nominated pharmacy to pick up your medication after the surgery's specified turnaround time for repeat prescriptions (48 hours).

Please tick **(one)** pharmacy nomination:

Blyth Health Centre Pharmacy Thoroton Street NE24 1DX Tel: (01670) 396 487	
Boots Maddison Street NE24 1EY Tel: (01670) 546 092	
Blyth Health Care Bowes Street NE24 1BD Tel: (01670) 362 111	
Boots Waterloo Road NE24 1BW Tel: (01670) 352 275	
Boots Cowpen Briardale Road NE24 5LA Tel: (01670) 356 545	
Boots Newsham Plessey Road NE24 4AA Tel: (01670) 366 198	
Asda Pharmacy Cowpen Road NE24 4LZ Tel: (01670) 542 710	
Boots Seaton Sluice Beresford Road NE26 4DR Tel: (0191) 237 6880	
Lloyds Delaval Terrace NE24 1DJ Tel: (01670) 366 608	

If you require any further information regarding electronic prescribing please ask a receptionist.

Application for online access to my medical record

Surname	Date of birth
First name	
Address Postcode	
Email address	
Telephone number	Mobile number

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

Booking appointments	☐
Requesting repeat prescriptions	☐
Basic Summary Information	☐

I wish to access my medical record online and understand and agree with each statement (tick)

1. I have read and understood the information leaflet provided by the practice	☐
2. I will be responsible for the security of the information that I see or download	☐
3. If I choose to share my information with anyone else, this is at my own risk	☐
4. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible	☐
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	☐
6. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible.	☐

Signature	**Date**

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
Date account created		
Date passphrase sent		
Level of record access enabled All ☐ Prospective ☐ Retrospective ☐ Detailed coded record ☐ Limited parts ☐		Notes / explanation