New Patient Questionnaire

Welcome to Brookside Surgery

In order to provide you with the best possible care, please fill in as much of this information as possible and bring it with you to your new patient check. Please note that we consider a new patient check essential for registration at the practice.

Personal Details

Full Name (including title)		Office Use
How would you like to be addressed? E.g Mr X, Sharon		
Address		
Date of Birth		
Marital Status	Single Married Divorced Separated	
Telephone (Home) ☐ Tick if preferred number		
Telephone (Mobile) ☐ Tick if preferred number		
Telephone (Work) ☐ Tick if preferred number		
Ethnicity (how would you describe yourself)		.9S
Email Address		
First Language		.131
Keysafe Code (If you have one)		.9189

Family History

Please complete the following boxes if any of your relatives have/had any of these problems:

Condition	Parent/Sibling/Child	Grandparent/Aunt/Uncle	Office Use	
Allergies (severe food/drug)			Y .12R	N .1222
Cancer (please give type)			Y .124 & select	
Diabetes			Y .1252	N .1228
DVT or Pulmonary Embolism			Y .12C9	N .122A
Heart Attack/Angina			Y .12C.	N .1226
High Blood Pressure			Y .12C1	N. 1227
High Cholesterol			Y .1262	
Hip Fracture			Y .1215	
Osteoporosis			Y .1268	N .1229
Pernicious Anaemia			Y .1277	
Stroke			Y 12C4	N. 1225
Thyroid Problems			Y .1251	

Current Medication

Please provide us with a copy of the repeat medication request slip which is provided to you by your previous GP. If you do not have this to hand please ask your previous GP to email/fax a list of these meds to:

Email: brooksidereception@nhs.net

Fax: 02476 545 617

We need accurate information in order to dispense to you properly.

For Women

Please circle if you use any of the following contraceptive methods:		061..
Pill (Combined contraceptive)	Pill (Cerazette or Mini-Pill)	Copper Coil
Mirena Coil	Depo-Provera Injections	Implanon (implant in arm)

Date of last smear (approximately)		.685

Allergies

Please list any drugs or substances (e.g nuts, eggs) that you are **allergic** to: i.e develop rash/swelling/anaphylactic shock
F4 Sensitivity & Tick Summary Box

Your Social Circumstances

Are you a carer for a relative/friend?		.918G
Do you have a carer?		.918F
Do you have significant mobility issues? (Housebound, Wheel-chair User, Very Poor Mobility?		.13CA .13CE
Are you blind/partially sighted?		.F49
Do you have problems with your hearing?		.F59
Do you have problems with your literacy (reading or writing)		.13Z5
Do you have problems swallowing tablets?		.8B394
Do you have problems with manual dexterity (using you hands)?		
What is your current occupation?		.0
If not currently working is this because you are unemployed (job seeking), incapacitated (off sick/disabled) or retired?		
Do you have any dependents living with you at home?		

For Children

Who has legal parental responsibility? (i.e. both parents, mother, father, grandparents, other)?	.918S
Which school(s) do they attend?	
Are there any issues at school that we need to know about?	.13Z2

Your Medical History

Do you suffer with/have ever had any of the following problems? Please give brief details as necessary

Cardiovascular (Heart & Circulatory) Problems
For example: Heart attack, angina, stroke/mini stroke, high blood pressure
Respiratory (Lung) Problems
For example: Asthma, chronic bronchitis, emphysema, tuberculosis
Gastrointestinal (Stomach and Bowel) Problems
For example: Irritable bowel syndrome, Crohn’s disease, ulcerative colitis, coeliac disease, diverticular disease, stomach/ duodenal ulcers
Genitourinary Problems
For example: Recurrent urine infections, significant kidney (renal) failure/abnormality, prostate problems, erectile dysfunction, abnormal smears (if so, what action was taken?)
Endocrine (Hormonal) Problems
For example: Diabetes, Thyroid (over/underactive)
Neurological (Brain & Nervous System) Problems
For example: Epilepsy, Parkinson’s disease, motor neurone disease, migraine, eye or visual problems (excluding glasses)
Musculoskeletal (Bones, Joints and Muscles) Problems
For example: Osteoarthritis, rheumatoid arthritis, gout, fibromyalgia, chronic fatigue, ME, osteoporosis
Mental Health Problems
For example: Anxiety, depression, dementia/memory problems, learning difficulties, personality disorder, bipolar disorder, schizophrenia, alcohol/drug dependence

Skin Problems	
For example: Eczema, psoriasis, skin ulcers	
Cancer	
Type and Date:	
Type and Date:	
Obstetric History	
Number of children given birth to	
Number of Caesarian Sections	
Number of Miscarriages/ Terminations of Pregnancy	
Blood Disorder	
For example: Blood clots (e.g. legs/lungs) clotting disorder (increased or decreased tendency to clot), anaemia	
Operations	
Name or Purpose of Operation & Approximate Date	
Name or Purpose of Operation & Approximate Date	
Name or Purpose of Operation & Approximate Date	
Name or Purpose of Operation & Approximate Date	
Name or Purpose of Operation & Approximate Date	
Anything else not covered elsewhere	

Alcohol

The above information is provided to help you answer the following questions. Please answer as honestly as possible

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

Smoking - Which of the following best describes you?

Current Smoker	Number/day:
Ex-smoker	Number/day: How many years? When did you stop?
Never Smoked	

Office Use:
Ensure all registrations have these left side headings in place:
.9 .66C .685 (females 25-65) .65 .64 (children <5y)
Recorded on NPQ.xls as given to patient ☐
Recorded on NPQ.xls as received by us ☐