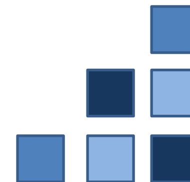
Pennine Medical Centre



NEW PATIENT QUESTIONNAIRE - ADULT

Please fill out this form in CAPITAL LETTERS

Patient Details

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other (please state)	**Address:**
First Name:	
Surname:	
Date of Birth:	
Gender:	**Postcode:**
Occupation:	**Home Tel No:**
Email:	**Mob No:**
Marital Status:	
Ethnic Origin:	

☐ White British	☐ Other Black	☐ Indian	☐ Do not wish to state
☐ White Irish	☐ White & Black Caribbean	☐ Pakistani	☐ Other Ethnic Group (please state)
☐ Other White	☐ White & Black African	☐ Bangladeshi	
☐ Black Caribbean	☐ Other Mixed	☐ Chinese	
☐ Black African	☐ Other Asian		

Next of Kin

Full Name:	**Relationship:**
Tel No:	**Mob No:**

Language Support

What is your first language:	**Do you use any of the following:**
Do you speak English: ☐ Yes ☐ No	**Sign Language:** ☐ Yes ☐ No
Interpreter Required: ☐ Yes ☐ No **If yes, which language?:**	**Hearing Aid:** ☐ Yes ☐ No

Additional Information

Religion:			
☐ Christian	☐ Muslim	☐ Hindu	☐ Other Religion (please state)
☐ Buddhist	☐ Jewish	☐ Sikh	
☐ No religion	☐ Do not wish to state		

Are you a Military Veteran? ☐ Yes ☐ No **If yes, do you give permission for this to be recorded in your medical records?** ☐ Yes ☐ No	**Are you a carer?:** ☐ Yes ☐ No **If yes, who do you care for?:**

Health Overview

Information from Self-Service Health Monitor:		
Height: cms	**Weight:** kgs	**BMI:**
Blood Pressure: /	**Pulse Rate:**	

Smoking Status:

☐ Never smoked ☐ Ex-smoker ☐ Current smoker – how many per day? ________

Alcohol Status:

Approximate number of alcohol units consumed per week _______

How often do you have an alcoholic drink:

☐ Never ☐ Once a month ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week

How many units of alcohol do you have on a typical day when you are drinking?

☐ 1-2 ☐ 3-4 ☐ 4-5 ☐ 5-6 ☐ 6 or more

How often do you have 6 or more (female) or 8 or more (male) units on one occasion?

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

Have you or a close relative ever had any of the following illnesses?:
***Please state nature of relationship**

	You	Relative*		You	Relative*
Asthma			**Diabetes**		
High BP			**Stroke**		
Glaucoma			**High Cholesterol**		
Cancer			**Depression**		
Other (please state):					

Do you consider yourself to have any disabilities?:

☐ No ☐ Yes – (please specify)

Do you have any allergies?:

☐ No ☐ Yes (please state)

Are you currently taking any medication?:

☐ No ☐ Yes (please state)

NB: if you are on repeat medication you must attach a repeat prescription slip to this questionnaire, you can request a copy from your previous GP surgery

Have you had any operations?:

☐ No ☐ Yes (please state)

Summary Care Record

Please read the information sheet within the new patient pack for information regarding the Summary Care Records. You may also wish to get further information from this website: https://digital.nhs.uk/services/summary-care-records-scr

If you do not complete this section of the form, the practice will assume implied consent to having a 'core' Summary Care Record.

After reading the information carefully, please tick ONE of the following boxes:

☐ YES – I would like a 'core' Summary Care Record (express consent for medication, allergies and adverse reactions only)

☐ YES – I would like a 'core and additional information' Summary Care Record (express consent for medication, allergies, adverse reactions and additional information)

☐ NO – I do not wish to have a Summary Care Record; by choosing this option I understand that, should an emergency arise, healthcare professionals will be unable to access information regarding any medication I am taking, any allergies I suffer from or any bad reactions to medicines I have. I understand that I can opt back in at any time by contacting my GP practice.

Communication

Text Messaging:

If you have a mobile phone number you can choose to opt in to receiving messages regarding appointment confirmations, appointment reminders, health campaigns (eg. flu jab). Please tick the following if you wish to opt in to this service:

☐ Yes – I agree to Pennine Medical Centre sending relevant text messages to my mobile phone number

Alternatively, you can download the app to receive the same messages: https://www.mjog.com/messenger/

Electronic Prescriptions (ePS)

Please read the dedicated information sheet within the new patient pack for full details. Electronic Prescriptions are mandatory at Pennine Medical Practice. Electronic Prescriptions does not mean that you have to request your repeat prescription electronically – you can see all the ways to order a repeat prescription on the 'Additional Information' sheet in the new patient pack.

You MUST nominate a pharmacy to where your prescription will be electronically sent. You can change your nominated pharmacy at any time by contacting the surgery.

My nominated pharmacy is:

☐ Chadwick & Hadfield, Mossley

☐ Well Greenfield, Chew Valley Road

☐ Other (please state name and address)

I confirm that I have read and understood all of the above information and give or do not give my consent as indicated in each section.

Print Name:	Signature:	Date:

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Pages 1 & 2 checked and coded: ☐	Repeat Px Slip Supplied: ☐	Consents (page 3) Actioned: ☐
Initials & Date:		
GP Appt Recommended: ☐ - specify reason:		Initials & Date: