

WOODSTOCK SURGERY NEW PATIENT QUESTIONNAIRE

Welcome to Woodstock Surgery. Please complete the new patient registration form and questionnaire as clearly and fully as possible. We will use this information to help care for you until your notes arrive from your previous practice. We will require some identification and proof that you are resident within our practice boundary. If you are registering from overseas please be aware that you may not automatically be entitled to secondary care under the NHS (for example hospital care). If you have repeat prescriptions please arrange a new patient check with a doctor.

Title and family name:	Date of birth:
First name:	CARERS
Home telephone number:	Do you have significant (unpaid) caring responsibilities for someone? Yes: <input type="checkbox"/> No: <input type="checkbox"/> Name: Relationship:
Mobile telephone number:	
Work telephone number:	
Address:	
Are you happy for this mobile number to be used for our Text messaging service to remind you of future appointments and recall? I consent to SMS <input type="checkbox"/> I do not wish to have text reminders sent to my mobile phone <input type="checkbox"/>	I have a carer: <input type="checkbox"/> Name: Telephone number:
Have you recently returned to the UK after residing abroad?	
Are you a Veteran? Yes: <input type="checkbox"/> No: <input type="checkbox"/>	

- **Use of your Medical Records**

If you require further information our reception can provide you with appropriate leaflets

NHS England's Care Data

The care data system aims to provide accurate information to citizens, clinicians and commissioners about treatment and care provided by the NHS. It is a tool for planning for the future and is not about the individual patient. If you do not wish your information to be shared outside the GP practice you can raise an objection.

I consent to the use of NHS England's Care Data

I wish to register an objection and receive an objection form

Please see over.....

The Summary Care record and Oxfordshire Care Summary

Please complete the separate form provided.

- **Medical History**

There is an automatic height and weight machine in the corridor which will provide you with a paper slip – this can then be attached to this form – please put your name on the slip.

Height:	Weight:
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Are you currently under medical care of any sort?
Current medication giving details of name, strength and frequency:
Do you suffer from any allergies?
Past clinical conditions including hospital admissions and operations

- **Family History**

If any members of your family have suffered from any of these illnesses, please state their relationship to you and whether they are on your mother or father's side. Please put the age of onset if you know it.

Condition	Relationship to you	Age of onset if known
Heart Attack		
Angina		
High Blood Pressure		
Stroke		
High Cholesterol		
Diabetes		
Cancer(+type)		
Thyroid disease		
Osteoporosis		
Senile dementia		
Glaucoma		
Asthma		

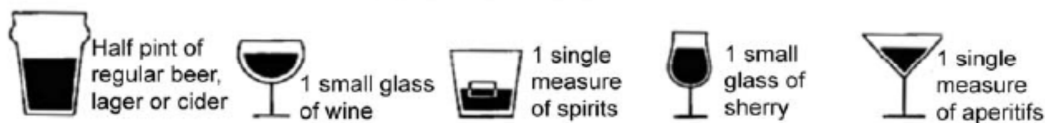
For female patients only:

Are you pregnant?	YES / NO	Due delivery date:
Details of past pregnancies:		
Have you had a cervical smear?	YES / NO	Date of last smear:
Have you had breast screening?	YES / NO	Date of last screening:
Have you had a hysterectomy?	YES / NO	Date:
Details of any contraception being used?		

Social History:

What is your occupation?
Have you any children? (please give age and sex)
Do you smoke? Never <input type="checkbox"/> No <input type="checkbox"/> Date stopped: e-cigarettes <input type="checkbox"/> <input type="checkbox"/> Yes – how many a day?
How physically active are you? Inactive <input type="checkbox"/> Fairly active <input type="checkbox"/> active <input type="checkbox"/> very active <input type="checkbox"/>

Alcohol Intake - This is one unit of alcohol...



...and each of these is more than one unit



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	

Scoring:

A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.



Ethnicity:

Country of origin:	
First language:	
Ethnicity	Please tick ✓
White	
White and black Caribbean	
White & Black African	
White and Asian	
Asian/Asian British, Indian/Pakistani/Bangladeshi/other	
Black/Black British	
Caribbean/African/ other Black background	
Other ethnic group	

Would you like to join our Patient Participation Group?

We actively seek the views of patients. Initial contact is through occasional email and your level of participation is your choice.

Please supply your email address:

Signed:

Date: