FOR OFFICE USE H/C appt date or full health check (40-74)
Identity Check **Residency Check**
eg Passport eg Utility bill
Signed up for online services? Y/N

Langley House Surgery
New Patient Health Questionnaire

Today's Date:

Please complete this confidential questionnaire (one for each member of the family to be registered with the Practice).

Please bring evidence of your identity (eg passport, photo driving licence) and proof of residency (eg utility bill showing your address)

Full Name:					**Telephone Number:**
Mr / Mrs / Miss / Ms / Other……..					**Work Number**
Address and Postcode					**Mobile Number:**
					E-mail Address:
Your Date of Birth		**Any previous surnames**			**I consent to the surgery texting me eg for appointment reminders Yes/No**
Marital Status		**Gender**	**Male:**	**Female:**	**Other residents of your home:**
Occupation					
Names & Ages of Children					

Next of kin	**Next of kin contact number**	**Next of kin relationship to you**	
Your Ethnic Origin: (select one)	**White (UK)**	**White (Irish)**	**White (Other)**
Caribbean	**African**	**Asian**	**Other Mixed Background**
Indian / Brit Indian	**Pakistani / Brit Pakistani**	**Bangladeshi / Brit Bangladeshi**	**Other Asian Background**
Other Black Background	**Chinese**	**Other**	**Ethnic Category not stated** ***For the EPS pharmacy (only practices with EPS)*** Setup Users and Policy Organisation Preferences Prescribing ETP pharmacies Custom Search ODS code: FDM71

			(typing in the postcode, name etc, does not work)

Your Religion:	**C of E**	**Catholic**	**Other Christian (state)**	**Buddhist**	**Hindu**	**Muslim**
	Sikh	**Jewish**	**Jehovah's Witness**	**No religion**	**Other religion (state)**	

Your main or 1st language Spoken / Understood:

Your Medical Background:

Have you ever had?	High Blood Pressure YES/NO	Epilepsy YES/NO	Asthma YES/NO	Kidney Disease YES/NO
	Heart Disease/Heart Failure/Atrial Fibrillation YES/NO	Stroke YES/NO	Diabetes YES/NO	Peripheral Vascular Disease YES/NO
Other serious illnesses or operations (with dates)				
Are you undergoing any regular treatment or follow-up?				
Please list any regular medication you take	1	2	3	
	4	5	6	
	7	8	9	
Are you able to administer your own medicines?	**Yes**	**No – please detail specific issues (e.g. swallowing, opening containers)**		
Do you have any allergies?				

Have any of your near family (parents, grandparents, brothers or sisters) ever suffered from?	**Diabetes (who?)**	**Asthma (who?)**	**Stroke (who/age?)**	**Heart disease (who/age?)**
	High Blood Pressure (who?)	**Cancer of the bowel (who/age?)**	**Breast Cancer (who/age?)**	**Osteoporosis (who/age?)**

Smoking, Alcohol Consumption and Exercise:					
Are you currently a smoker?	**Yes**	**No**	**Have you ever been a smoker?**	**Yes**	**No**
If so, how many cigarettes / cigars / tobacco do you smoke in a week?			**How much alcohol do you drink in a week (Units)?** *(One unit = 1 small glass of wine, a single measure of spirits, or 1/2 a pint of beer)*		
If you are a smoker and want to stop, please ask for information about local smoking cessation services.					
How often do you exercise?	**No. times per week**		**Type(s) of exercise:**		

Specific Needs: Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:			
Please state any Sensory Impairment you have (i.e. Speech, Hearing, Sight):			
Are you an 'Assistance Dog' User?			
Please state any Physical disabilities you have:			
Please state any Mental disabilities you have:			
Please state any requirements you have to be able to access the Practice premises			
Please state any Religious or Cultural needs:			
Do you require the help of a Translator / Interpreter?			
If you are a Carer, please state the name / address / phone number of the person you care for:	**Person Cared For Contact Details:** **Their relationship to you:-**		
If you have a Carer, please state their name / address / phone number and sign here if you wish us to disclose information about your health to your Carer.	**Carer Contact Details:** **Their relationship to you:-** **Signed:** **Date:**		
Do you have a "Living Will" (a statement explaining what medical treatment you would not want in the future)?	**Yes / No**	***If "Yes", can you please bring a written copy of it to your New Patient Consultation***	
Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)?	**Yes / No**	**If "Yes", please state their name / address / phone number:**	

Women only:				
When was your last smear done?	**Date**	**Was this at your GP's Surgery?**	**Yes**	**NO**
What was the result of the smear?				
Date of last mammogram (if applicable):	**Date**	**Method of contraception (if used):**		

Summary Care Records.

The NHS in England has introduced the Summary Care Record, which will be used in emergency care (eg if you attend A&E or call an out of hours doctor). The record will ONLY contain information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had, to ensure those caring for you have enough information to treat you safely.

Your Summary Care Record will be available to authorised healthcare staff providing your care anywhere in England, but they will ask your permission before they look at it. This means that if you have an accident or become ill, the doctors treating you will have immediate access to important information about your health.

Your GP practice is supporting Summary Care records and as a patient you have a choice:

• **Yes I would like a Summary Care Record** – you do not need to do anything and a Summary Care Record will be created for you.

• **No I do not want a Summary Care Record** – please tick No below and sign the form at the bottom.

More information can be obtained from www.nhscarerecords.nhs.uk or information line 0300 123 3020

Are you happy to have a Summary Care Record?	**Yes**	**No**	

Do you want to help your new Surgery?

This practice is committed to improving the services we provide to our patients. We would like to be able to email our patients occasionally to ask them their views about the surgery and how well we are doing, to identify areas of improvement.

Yes, I am interested in becoming involved in the Virtual Patient Group (Please tick the "Yes" Box)	**Yes**

Patient Signature:		**Signature on behalf of Patient:**	

OTHER INFORMATION FOR NEW PATIENTS:

If you have not already been given:

- **our practice leaflet**
- **appointments timetable and**
- **information about how appointments system works, including online booking**
- **online access to services**

then please ask at reception.

Thank you for completing this form