EVIDENCE REQUIRED – This is an NHS requirement
Proof of Identification ie Passport / Driving Licence / Birth Certificate – PLUS a Utility Bill or similar (within last 3 months) showing Name and Address (address to be your NEW / CURRENT address).

IDENTIFICATION SEEN: .....

GREENWOOD SURGERY – NEW PATIENT MEDICAL QUESTIONNAIRE

To ensure our records are up to date we would appreciate you completing this form. The information is for our use only and is Strictly Confidential.
We operate a ZERO TOLERANCE policy for Threats of Violence, Aggressive behaviour or gratuitous rudeness, PATIENTS are asked to SIGN HERE to agree to this policy: .....

Name: ..... **Date of Birth:** .....

Home Tel. No: ..... **Date of Completing Form:** .....

Mobile Phone No: ..... **Email:** .....

Work Phone No: ..... **Preferred Chemist:** .....

Are you a Carer: ? ..... **Who for: ?** .....

Please could you state the following: Do you have any Family History of any of the following?
(Please tick the relevant boxes and state the relationship to you e.g: Mother, Brother etc. and their age) Put **N/A** where not applicable

Stroke	☐	Relationship:	Age: .....
Heart Attack	☐	Relationship:	Age: .....
High Blood Pressure	☐	Relationship:	Age: .....
High Cholesterol	☐	Relationship:	Age: .....
Thyroid Disorders	☐	Relationship:	Age: .....
Diabetes	☐	Relationship:	Age: .....
Asthma	☐	Relationship:	Age: .....
Cancer (please state Type)	☐	Relationship:	Age: .....

Have you had any Significant/Serious Illness? If so please give approximate dates (*continue overleaf if necessary*)

.....

.....

Have you had any Operations? If so please give approximate dates (*continue overleaf if necessary*)

.....

.....

Medication: List any Medication you are currently taking, and the illness you are taking them for (*continue overleaf if necessary*).

.....

.....

.....

Allergies: Are you Allergic to, or sensitive to any food, animal's etc.?.....

Immunisation: Please tick if you have been Immunised against the following, and if possible give dates.

☐ Diphtheria..... ☐ Polio..... ☐ Tetanus.....

☐ Measles..... ☐ Mumps..... ☐ Rubella.....

FEMALE ONLY

Do you use a contraceptive? **YES / NO** If YES, what do you use? .....

Have you had a cervical smear? **YES / NO** If YES, when was it? ..... What was the result? .....

Have you had any children? (If so, please give Sex and Date of Birth): .....

.....

.....

SUMMARY CARE RECORD – You have a choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care. Your options are outlined below; please indicate your choice on the form overleaf.

Express consent for medication, allergies and adverse reactions only. You wish to share information about medication, allergies for adverse reactions only.

Express consent for medication, allergies, adverse reactions and additional information. You wish to share information about medication, allergies for adverse reactions and further medical information that includes: your illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.

Express dissent for Summary Care Record (opt out). Select this option, if you **DO NOT** want any information shared with other healthcare professionals involved in your care.

PLEASE TURN OVER

If you chose not to complete this consent form, a core Summary Care Record (SCR) **will** be created for you, which will contain only medications, allergies and adverse reactions. Having read the above information regarding your choices, please choose **ONE** of the options below and return the completed form to your GP practice:

YES – I would like a Summary Care Record

☐ Express consent for medication, allergies and adverse reactions only.

or

☐ Express consent for medication, allergies, adverse reactions and additional information.

or

NO – I would not like a Summary Care Record

☐ Express dissent for Summary Care Record (opt out).

You must choose from ONE of the boxes on the left

Height: ..... Weight: ..... Waist: .....

Present Occupation: .....

Blood Pressure - Systolic: ..... Diastolic: ..... Pulse: .....

Smoker?: ..... If yes, year started: ..... How many per day: .....

If Ex-Smoker, year stopped: ..... Smoking Cessation Advice Given: .....

Exercise Grading: ..... Diet: .....

URINALYSIS: Protein: ..... Glucose: .....

Current Health Problems: .....

.....

.....

Other Notes or Comments: .....

.....

Questions	**Scoring System – A**					
	0	**1**	**2**	**3**	**4**	**Your Score**
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 - 8	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.			**SCORE from ABOVE**			

If the score from System A is 5 or greater then System 2 must be completed

Questions	**Scoring System – B**					
	0	**1**	**2**	**3**	**4**	**Your Score**
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 Higher risk, 20+ Possible dependence **SCORE**