You will need to be seen in our chronic disease clinics if you take regular medication for any of the illnesses listed below.	
Illness/Condition	**Please indicate if you suffer from these illnesses and will need to attend the relevant clinics in the near future.**
Asthma	
Anti-coagulation (INR)	
Cardiovascular Disease	
COPD	
Diabetes	
Epilepsy	
High Blood Pressure	
Hypertension	
Mental Health	
Rheumatology	
Substance Misuse	
We are happy to offer you a New Patient Health Check within the next 6 months. Please telephone the surgery 2 weeks after completion of this form to book an appointment if you would like one. (Only suitable for 15yrs or above)	
Summary Care Record **Please indicate if you consent to sharing a summary of your Medication, Sensitivities, Allergies and Adverse Reactions to other Health Care Professionals in an emergency situation. Examples may include contact with GP out of Hours service, Emergency visits to A&E and being seen as a Temporary Resident by a GP whilst on holiday etc. A leaflet regarding Summary Care Records is available on request.**	
I **consent** to my Medication, Sensitivities, Allergies and Adverse Reactions to be included in the Summary Care Record.	I **do not** wish to be included in the Summary Care Record but understand that I can change my mind regarding this at any time.
Signed:	Signed:
	If you have decided to opt out of the Summary Care Record you **must** complete an Opt-out form. These are available from Reception.
You may want to include other important information on your Summary Care Record which you think would be helpful in an Emergency situation. Please speak to a member of staff for further details. Additional information will only be shared with your express consent.	

Thank you for taking time to complete this questionnaire.
Please return it to reception where your registration will be processed.

Newbold Surgery

New Patient Questionnaire

Please take time to complete the following questionnaire.
This will enable us to assess any treatment you may need in the near future.
Any other medical history will be transferred from your medical records when we receive them from your previous GP.

Please complete ALL questions

Full Name:	Today's Date: Sex:
Address: Post Code:	Marital Status: Ethnic Origin: (Please circle) White British White Other Chinese Asian Indian Asian Pakistani Asian Chinese Asian Bangladeshi Asian Other Black Caribbean Black Other Black African Mixed – White/Black African Mixed – White/Asian Mixed - Other Mixed – White/Black Caribbean Other Ethnic Background ……
*Home Tel: *Mobile Tel:	
I consent for communications to be sent via text message and email. Signed:	
I **DO NOT** consent for communications to be sent via text message and email. Signed:	
*Work Tel: (Optional)	
Email Address:	
Next of Kin: Relationship: Address: Tel No:	Date of Birth: *NHS Number:
***It is extremely important that we have up to date telephone numbers in case we have to contact you urgently.**	*Your NHS No. **MUST** be completed, without it we can not process your application. (You can obtain this number from your previous GP)

Do you have any learning disabilities?	Yes	No
Do you have a carer?	Yes	No
Are you a carer?	Yes	No

If you answered yes to either of the carer questions, please ask at reception for a carers pack.

Height:	Weight:
When was the last time you had a blood pressure check?	
Do you suffer from any allergies?	
Are you sensitive to any medication?	
Are you a member of the Armed Forces?	
Have you ever served in the Armed Forces?	
Are you the partner or child of a member or previous member of the Armed Forces?	

Do you smoke? 	Yes	No	If you are a **current** smoker How many per day? Cigarettes: Cigars: Pipe: Rolling Tobacco:
Have you ever smoked?	Yes	No	
Date stopped smoking?			

Stop Smoking Cessation Advice

If you would like advice and support to help you to stop smoking you can self-refer toone of our local NHS Stop Smoking Services. For FREE local support call: Derbyshire County Stop Smoking Service on 0800852299 or 01246 868425. Alternatively www.nth.nhs.uk/stopsmoking has more information. Some Pharmacies also offer this service.

Alcohol Consumption Questions	**0**	**Scoring System 1**	**2**	**3**	**4**	**Your Score**
How often do you have 8 (men)/6 (women) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Only answer the following questions if your score above is 2 or more.

How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative/friend/ doctor/health worker been concerned about your drinking or advised you to cut down?	Never		Yes, but not in the last year		Yes, during the last year	

Units of Alcohol

2 units	**1.5 units**	**2 units**	**1 unit**	**9 units**
				
Pint of Regular Beer/Lager/Cider	Alcopop or Can of Lager	Glass of Wine (175ml)	Single Measure of Spirits	Bottle of Wine

Females Only		
Are you currently Pregnant:	Yes:	No:
Which method of contraception do you use?		
Approximate date of your last smear test?		
Approximate date of your last breast screen?		