The Devonshire Lodge Practice
New Patient Questionnaire
New Patient Registration Questionnaire (14 + years)
Welcome to our surgery
Please complete this form clearly in capital letters using black ink.

As part of our commitment towards improving health we expect:

- All qualifying women (25 to 65 years) to be up-to-date with cervical screening.
- All patients with chronic medical conditions (e.g. heart disease, diabetes, asthma, epilepsy, chronic lung disease, etc.) should make an appointment with our nurse as soon as possible.
- If you are on repeat medication please ensure you have at least 4 weeks supply from your current GP to cover the transfer period.

Personal Details
Title: Mr / Mrs / Miss / Ms/ Other ________ Date of Birth ____________ Sex _________
Forename ___________________________ Surname ______________________________
Previous Surname ___________________ Religion _______________________________
Marital Status Town & Country of birth

Contact Details
Address ____
____ Post Code ___________
Home Phone _______________________ Mobile Phone __________________________
Work Phone ________________________ Email ________________________________
Preferred method of communication: ____
You may receive text /e-mail reminders for your appointments from the surgery. If you do not wish to receive these texts please tick □ e-mail alerts please tick □

Do you live in a Care / Nursing home? Y / N Are you medically Housebound? Y / N
Are you Registered Disabled? Y / N
If Yes, please give details ____
If you need information in a different format or communication support please give details

Next of Kin Details
Name _______________________ Relationship ____________ Phone No ____________
Address

Carer Status
Do you care for anyone else? Yes / No ______________
If yes, Name of person you care for ____
Do you have anyone who looks after you or your daily needs as Carer? Yes / No

General Health
Height ________________ Weight _________________
Do you smoke? Yes / No If yes Cigarette Pipe Other
How many / much per day? _________________________________
Are you an ex-smoker? Yes / No When did you stop? ________________
How many did you smoke per day? ____
Do you have any special dietary requirements? Yes / No Please specify ______________
Exercise level: None Light Moderate Vigorous
Number of hours/week: What form of Exercise:

Immunisation
Allergies
List any drugs, plasters, food, animals, etc.
Please give details
____
Date of last Tetanus
____
Any other immunisation
____
The practice is offering TB screening please ask the practice to see if you are in this priority group.

Past & Present Medical History
Please give details of any chronic medical condition, hospital treatment, accidents, and special investigations ____
Condition____
Month / Year____

Medication
Please list below all Medication you are currently taking or Attach a copy of your Repeat Prescription Request Form (Please ensure you have enough supply for the interim period)
Name____
Strength____
Dose____

The Electronic Prescription Service (EPS) is an NHS service.
Are you registered for EPS? Yes / No
If Yes, please amend your nominated pharmacy accordingly
If you wish to have further details or an application form, please contact our Prescription Desk once fully registered.

For Office Use Only
Medication checked and approved for entry on Patient’s Medical Records □
Doctor’s signature Date

Family History
Is there any of the following in your family (father, mother, brother, sister)

Condition	Yes / No	Which Family Member
Diabetes		
Hypertension		
Heart disease before age 60 (Heart Attack, Angina)		
Stroke		
Epilepsy		
Any other		

For Female Patients Only
Have you had a cervical smear? ____________________ Yes / No ___________
If Yes, When was it last done? ______________________ Result _____________
Where was it done? ___________ Previous GP Other Abroad
If outside UK, please provide a copy of the result.
Have you Contraception needs Yes / No
If Yes, Current method ____
Have you had a Hysterectomy? Yes / No Date
____

Alcohol Intake Questionnaire

1. How often do you have a drink containing alcohol?
- ☐ 0 – Never
- ☐ 1 – Monthly or less
- ☐ 2 – Two/Four times per month
- ☐ 3 – Two/Three times per week
- ☐ 4 – Four or more times per week

2. How many drinks containing alcohol do you have on a typical day?
- ☐ 0 – None/One or Two
- ☐ 1 – Three or Four
- ☐ 2 – Five or Six
- ☐ 3 – Seven or Eight
- ☐ 4 – Ten or more

3. How often do you have Six or more drinks on one occasion?
- ☐ 0 – Never
- ☐ 1 – Less than monthly
- ☐ 2 – Monthly
- ☐ 3 – Weekly
- ☐ 4 – Daily or almost daily

Ethnic Group – 16+1 codes

What is your ethnic group? *Choose ONE section from A to E, then tick the appropriate box to indicate your ethnic group.*

A: White
- ☐ British
- ☐ Irish
- ☐ Any other White background (please write in)

B: Mixed
- ☐ White & Black Caribbean
- ☐ White & Black African
- ☐ White & Asian
- ☐ Any other mixed background (please write in)

C: Asian or Asian British
- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Any other Asian background (please write in)

D: Black or Black British
- ☐ Caribbean
- ☐ African
- ☐ Any other Black background (please write in)

E: Chinese or other ethnic group
- ☐ Chinese
- ☐ Any other (please write in)

☐ **Not Stated**

You will automatically be registered for Patient on line services. If you do not want to use this service please tick ☐ and sign____

Summary Care Record

I confirm I have received and understood information regarding Summary Care Record and (please tick approriate box) :-

- Express consent for medication, allergies and adverse reactions only
- Express consent for medication, allergies, adverse reaction AND additional information
- Express dissent (opt out) I do not want a Summary Care Record

(Please sign) ____

Thank you for taking time to fill out the questionnaire

As well as completing this form you need to fully complete A GMS1 form which can be found here https://www.gov.uk/government/publications/gms1

Last updated by NK 24/3/2020