Sloan Medical Centre
Health - Social - Self Care

www.sloanmedicalcentre.co.uk

NEW PATIENT QUESTIONNAIRE

The information that we are seeking on this form is to help us offer you the best advice and treatment that we can. Please tell us as much as you can and return this form to the surgery together with the registration form and two documents to verify your identity.

Your communication requirements Do you need written information in a format other than standard print? If so what are they?..... YES / NO

ABOUT YOU

Date of Birth		Title		
Surname		Forename(s)		
Previous Surname		Occupation		
Address Post Code		Home Phone		
		Mobile Phone		
		E-Mail Address (We may contacted you by email)		
Marital Status (circle as appropriate)	Married or Civil Partnership	Widowed	Divorced or Separated	Single
Contact method (circle all appropriate)	SMS	EMAIL		LETTER
Are you a military veteran?				
Nominated pharmacy				

Do you agree to receiving SMS texts messages for appointment confirmations and reminders? Y / N

Details of parent or guardian (if under 18)

YOUR ETHNIC GROUP – How would you describe your ethnicity? (circle the appropriate group)

White British	White Irish	Other White Background	
Mixed White and Black Caribbean	Mixed White and Black African	White and Asian	Other Mixed Background
Indian	Pakistani	Bangladeshi	Other Asian Background
Caribbean	African	Other Black Background	
Chinese	Other Ethnic Group		Declined To Say

YOUR FIRST LANGUAGE

First Language	
Consultations are in English. Please indicate if you will need the services of an interpreter	Yes / No

YOUR HEIGHT AND WEIGHT

Height (indicateunits used e.g. feet & inches or cms		Weight (indicate units used e.g. stones & pounds or kgs	

SMOKING

Do you smoke?	YES / NO	Have you ever smoked?	YES / NO
If you are an ex-smoker:			
When did you stop? (approx. month & year)		How much did you smoke before giving up? (cigarettes/day or grams tobacco/week)	
If you are a current smoker:			
What do you smoke? (circle as appropriate)	Cigarettes/cigars/pipe	How much do you currentlysmoke? (cigarettes/day or grams tobacco/week)	
Would you like help to stop smoking?	YES / NO	If you are a smoker and you wish to have help to stop smoking, please make an appointment with one of our smoking advisors for help and advice.	

Alcohol

Alcohol use can affect your health and can interfere with certain medications and treatments. Your answers will remain confidential so please be honest.

Use the guide below to decide how many units you drink a week.

Fast alcohol screening test (FAST)

FAST is an alcohol harm assessment tool. It consists of a subset of questions from the full alcohol use disorders identification test (AUDIT). FAST was developed for use in emergency departments, but can be used in a variety of health and social care settings.

Questions	Scoring system					Your score
	0	1	2	3	4	
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	
Only answer the following questions if the answer above is Never (0), Less than monthly (1) or Monthly (2). Stop here if the answer is Weekly (3) or Daily (4).						
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 been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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	

FAST score	

Scoring:

A total of 5+ indicates increasing or higher risk drinking.
If your score is 5+ you may be asked to fill in a further questionnaire during a New Patient Check appointment with one of our nursing team.

YOUR MEDICAL HISTORY

Do you live with any of the following conditions? (please provide approximate date of diagnosis below)			
Diabetes Type 1	Diabetes Type 2	Hypertension (high blood pressure)	Epilepsy
Heart Disease	Mental Health	COPD/Emphysema	Asthma
Cancer	Deafness/hard of hearing	Blindness/partial sight	
If so, when was your last check-up?			
Have you had any serious illnesses, accidents or operations?			
Please list all events with dates			
Are you allergic to anything? (e.g. aspirin, penicillin, bee stings, sticking plasters)			
Covid vaccine dates			

REGULAR HEALTH MONITORING

Please let us know if you are currently on any regular monitoring such as Methotrexate or INR Y / N

Please specify:……..

YOUR FAMILY HISTORY

Have your parents, brothers or sisters had any of the following conditions before the age of 60?			
Diabetes		Asthma	
High Blood Pressure		Hay Fever	
Heart Attack		Epilepsy or Fits	
Stroke		Other Conditions	

CARERS AND THE CARED FOR

Are you a Carer?	Yes/No
If you are a carer, please state the name/ address/ and relationship of the person you care for.	
Is the person you care for registered with this practice?	Yes/No (delete as appropriate)
Signature	

Does someone care for you?

If someone else cares for you, it is important for us to hold this information in your medical record, please sign below if you wish us to disclose information about your health to your carer.

If you are cared for, please state your carers/ address/ your relationship with the person who cares for you.	
Is the person you care for registered with this practice?	Yes/No (delete as appropriate)
Signature	

Sharing your record

Patient Consent Form

We recognise the importance of protecting personal and confidential information in all that we do, and we will take care to meet our legal duties, as the law determines how organisations can use the personal information that we collect.

To support our statutory obligations, we must inform you of who we will share information with and allow you to determine whether or not you wish us to share the information that we have recorded about you within your patient record. You have the right to withdraw consent at any time and also to change who you wish us to share your information with. Should this be the case, we will inform the relevant partner organisations and advise them of your decision.

I, ...(Print Name), give/does not give (delete as appropriate) consent for my information to be shared to discuss the care that is provided to identify services and resources which could support my health and wellbeing.

For further information on who we share with and what steps we take to protect the information we hold, please speak to our patient advisors.

Please tick against each data set identifying if you wish/do not wish to share data

Record Sharing Initiative	I hereby give consent for my information to be shared.	I do not consent for my information to be shared.
Summary Care Record		
Care.Data		
Local Shared Care Record (local providers only)		