BARROW HEALTH CENTRE

NEW PATIENT QUESTIONNAIRE

Title:_____ **DOB**_____

Surname:_____ **Previous Surname:**_____ **Forenames:**_____

My ethnic origin is – (Please tick)

- ☐ White British
- ☐ White / Black Caribbean
- ☐ Mixed
- ☐ Chinese
- ☐ Indian
- ☐ Black African
- ☐ Pakistani
- ☐ Other Please state_____

Telephone no (inc STD code):_____ **Mobile no:**_____ **Email address:**_____

Approx. Height: _____ **Approx. Weight:** _____

Do you smoke? (Please tick)

- ☐ I have never smoked
- ☐ I do not currently smoke but have in the past
- ☐ Yes Please state how many: _____

Would you consider help to stop?

- ☐ Yes
- ☐ No

Do you drink?

- ☐ Yes
- ☐ No

If yes, how often do you have a drink containing alcohol?

Questions	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	7-9	10+
How often do you have 6 or more on one occasion?	Never	Less than Monthly	Monthly	Weekly	Daily or Almost Daily

If you have a communication difficulty ie hard of hearing or Partially sighted PLEASE TICK or inform us

If we need to contact you what is your preferred choice of communication? - PLEASE TICK PREFERENCE

1. Letter 2. Email 3. Telephone Are we able to leave a message on answer machine or with a family member ? Yes No

Do you care for somebody? Yes / No - If Yes relationship to you .....

Signature: ---------- **Date :** ----------

Do you have a nominated Pharmacy for the Electronic Prescription Service (EPS)?

If yes, please state the name and address of that Pharmacy _____

(please turn over)

FOR LADIES ONLY

Date of last smear?_____
Where was it last taken?_____
Was it normal?

- ☐ Yes
- ☐ No

If no, when is your next smear due?_____

IMPORTANT

Summary Care Record (SCR)

The SCR provides a summary of patient medical records to –
Authorised Healthcare staff treating them anywhere in the NHS England. This summary includes:-
Allergies and allergic reactions, current medication, medication issued in last 12 months, past repeat medications ended in last 6 months.
In the future the contents may include relevant conditions such as Diabetes, Cancer, Heart Disease or other life changing conditions.
At any time in the future you will be able to change the consent to NO consent or Vice-Versa

Please tick and sign for either

- ☐ I give my consent
- ☐ I do not give my consent

Electronic Patient Record Sharing (EDSM)

When you are seen by a Healthcare Professional, you can choose to permit or restrict access to the information entered into your record at each Healthcare organisation that accesses your record.
You will be asked to give sharing consent at each organisation at which you receive care. Your consent can be changed at any time.
Do you consent to sharing of data recorded here with any other organisations that may care for you?

- ☐ Yes – share data
- ☐ No – do not share data

Do you consent to us viewing data recorded by other organisations that may care for you?

- ☐ Consent given
- ☐ Consent refused

Do you consent to receiving Text Messages and text reminders?

- ☐ Consent given
- ☐ Consent refused

Signature_____ Print Name_____