New Patient Questionnaire

New Patient Questionnaire v1.5

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| **ABOUT YOU** | **STAFF USE** |
| Title: |       | Full Name: |       |  |
| Preferred name:(If differs to registered name) |       | Date of Birth: |       | [ ]  ACTION: Add preferred name in Registration using ‘Known As’ tab |
| Address: |       | [ ]  ACTION: Consider Social Prescribing Referral if housing issues |
| If you are currently without a home address, please discuss with a member of staff. |  |
| Telephone: |       |
| Email Address: |       | [ ]  ACTION: Set preferences in Additional Registration section |
| Please tick if you **DO NOT** wish to be contacted by: | Text [ ]  | Email [ ]  |
| Next of Kin Name: |       | Relationship: |       | [ ]  ACTION: Add NOK/Parent Names in Family/Relationships in Registration section |
| Next of Kin Telephone: |       |
| *If you are registering with us because you have recently left prison, please consider discussing this with the GP. We may be able to request that relevant medical records be transferred to continue your ongoing care* |  |
| **FOR CHILDREN UNDER 16** |  |
| Name of School: |       |  |
| Health Visitor/School Nurse:(If known) |       |  |
| Social Worker:(If applicable) |       |  |
| Parent/Carer 1 Name: |       | Relationship: |       | [ ]  ACTION: Add NOK/Parent Names in Family/Relationships in Registration section |
| Parent/Carer 1 Telephone: |       | Parental Responsibility: | Yes [ ]  | No [ ]  |
| Parent/Carer 2 Name: |       | Relationship: |       | [ ]  ACTION: Add detail under Family/Relationship Links in Registration |
| Parent/Carer 2 Telephone: |       | Parental Responsibility: | Yes [ ]  | No [ ]  |
| Is there currently a Child Protection Plan or Child in Need Plan in place? | Yes [ ]  | No [ ]  | [ ]  ACTION: Bring to the attention of the Safeguarding Lead |
| Is this child a Looked After Child (sometimes known as foster care)? | Yes [ ]  | No [ ]  |
| Does the family have an EHAT (Early Help Team Around the Family)? | Yes [ ]  | No [ ]  |
| **OPTIMISING HEALTH** | **STAFF USE** |
| Your electronic health records should transfer from your old GP in the coming weeks. This section ensures we get to know your health needs before the transfer is complete. If you are not sure about some of the answers, we can check them once your health records have transferred. |  |
| **For parents completing this on behalf of their children, please leave blank the sections that do not apply to them.** |  |
| [ ]  |  I am over 40 – *if you have never had a routine health check, please request a nurse appointment.* |  |
| [ ]  | I am under 40 and have some health problems (including current mental health problems) *– if you would like to discuss these, please make an appointment.* |  |
| [ ]  | I am under 40 and have learning disabilities *– we will aim to invite you to a health check.* | [ ]  ACTION: Bring to attention of the LD Lead  |
| [ ]  | I am under 40, and do not have medical problems. |  |
| *For everyone: If the blood pressure machine is available, you are welcome to use this without an appointment. Please inform reception of your blood pressure reading.* | [ ]  ACTION: Point out the available BP machine |
| Current Weight: |       | Height: |       | [ ]  CODE: Body weight [ ]  CODE: Standing Height[ ]  ACTION: Calculate BMI and offer appointment if needed |
| *If your BMI is 30 or above, we may offer you a nurse appointment.* |
|  |
| **IMMUNISATIONS AND VACCINATIONS** |  |
| **Adults** | **Children** |  |
| [ ]  | I have had everything I have been offered | [ ]  | My child has had everything that has been offered | [ ]  ACTION: Bring to the attention of the nurse |
| [ ]  | I think I might be missing some | [ ]  | My child has not had every immunisation that has been offered |
|  |  |
| **WOMEN’S HEALTH** |  |
| Are you currently pregnant? | Yes [ ]  | No [ ]  | [ ]  ACTION: Offer midwife appointment |
| Are you up to date with your cervical smear screening?(Only applicable to females aged 25-64 with a cervix) | Yes [ ]  | No [ ]  | Not sure [ ]  | [ ]  ACTION: Offer nurse appointment |
|  |  |
| **GENERAL HEALTH** |  |
| Do you currently smoke? | Yes [ ]  | No [ ]  | Never [ ]  | [ ]  CODES: - Never Smoked tobacco - Cigarette smoker- Rolls own cigarettes- Current smoker (for vaping)- Ex-smoker |
| Cigarettes:(Per day) |        | Tobacco:(Grams per week) |        | Vaping:(Per day) |        |
| Are you an ex-smoker? | Yes [ ]  | No [ ]  |
| If yes, when did you stop? |       |
| *If you continue to smoke, we encourage you to get support when you decide to quit. Visit* ***www.smokefreeliverpool.co.uk*** *for advice and more information on the benefits of stopping.*New Patient Questionnaire v1.5Page 2 | [ ]  CODE: Smoking Cessation Advice  |
| **GENERAL HEALTH (CONTINUED)** | **STAFF USE** |
| Do you drink alcohol? | Yes [ ]  | No [ ]  | How much? |       units per week | [ ]  CODE: Alcohol units consumed per week  |
| *A unit is half a pint, a small glass of wine or a single shot* |
| Questions | 0 | 1 | 2 | 3 | 4 | Your Score |  |
| How often do you have a drink that contains 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 have 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 units, if female, or 8 or more units if male, on one occasion in the last year?  | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |       | [ ]  CODE: AUDIT-C Score |
| Total: |       |
| *If you are drinking more than 14 units each week, this is higher than is recommended and could lead to health problems. You might like to contact Liverpool Community Alcohol Service on 0151 471 7784 or make an appointment in the surgery to discuss this more.* | [ ]  CODE: *(Only if more than 14 units per week)* Education about alcohol consumption |
|  |  |
| **MEDICATIONS** |  |
| Are you taking any prescribed medicines or contraceptive pills? | Yes [ ]  | No [ ]  |  |
| *If* ***yes****, please continue with the following questions.* |  |
| Do you receive your medication in a blister pack? | Yes [ ]  | No [ ]  | [ ]  CODE: Uses dispensed monitored dosage system |
| Do you have any questions or concerns about your medication? | Yes [ ]  | No [ ]  |
| If yes, please explain further: |       | [ ]  ACTION: Bring to the attention of the pharmacist |
| Do you regularly take codeine, co-codamol, dihydrocodeine, co-dydramol, tramadol, diazepam or zopiclone? | Yes [ ]  | No [ ]  | [ ]  ACTION: Bring to the attention of the pharmacist |
| Please state what pharmacy you wish to nominate to receive your electronic prescription:(NB: You can change your pharmacy at any time) |       | [ ]  ACTION: Update pharmacy nomination |
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| **OPTIMISING ACCESS** | **STAFF USE** |
| This section ensures we understand what specific needs you may have so that we can make sure everyone has equal access, outcomes, and experiences. | [ ]  CODE: Choose appropriate Ethnic Category code  |
| *Please indicate your ethnic origin by ticking* ***one*** *box.*  |
| **Asian or Asian British**  | **White** |
| Indian | [ ]  | British | [ ]  |  |
| Pakistani | [ ]  | Irish | [ ]  |  |
| Bangladeshi | [ ]  | Gypsy or Irish Traveller | [ ]  |  |
| Chinese | [ ]  | Roma | [ ]  |  |
| Any other Asian Background | [ ]  | Any other White Background | [ ]  |  |
| **Mixed** | **Black or Black British** |  |
| White and Black Caribbean | [ ]  | Caribbean | [ ]  |  |
| White and Black African | [ ]  | African | [ ]  |  |
| White and Asian | [ ]  | Any other Black Background | [ ]  |  |
| Any other Mixed Background | [ ]  |  |
| **Other** |  |
| Arab | [ ]  | Unknown | [ ]  |  |
| Any other ethnic group | [ ]  | Prefer not to say | [ ]  |  |
| *(Based on 2021 Census Groups)* |  |
| Country of Birth: |       | [ ]  CODE: Born in … |
| *Registering with a GP is free, and* ***all medical care you receive in our surgery is free****. You can always access healthcare here, even if you are not living in the UK legally. Although GP care is free, there may be charges if you need a prescription or to access hospital care.* *We will not ask you about your legal status, including before we refer you to hospital, but if you are concerned about this and the potential charges, do talk to your GP. Your legal status will not affect their medical care for you, and it may help them to treat your condition better if they understand your situation.* *You are* ***not required*** *to answer the following question, but it can be helpful to your GP if they know that you might have experienced some trauma, may be going through an ongoing stressful situation, or may have specific medical needs related to this. You can choose not to answer this question;* ***it will not affect your treatment.*** |  |
| Are you an asylum seeker? | Yes [ ]  | No [ ]  | Prefer not to say [ ]  | [ ]  CODE: Asylum Seeker |
| Are you a refugee? New Patient Questionnaire v1.5Page 4 | Yes [ ]  | No [ ]  | Prefer not to say [ ]  | [ ]  CODE: Refugee and tick to record as problem |
| **LANGUAGE** | **STAFF USE** |
| First Language: |       | [ ]  CODE: Main Spoken Language … |
| Interpreter required? | Yes [ ]  | No [ ]  | [ ]  CODE: Interpreter Needed OR Interpreter Not Needed |
| Do you require a British Sign Language interpreter?  | See the source image | See the source image | [ ]  CODE: British Sign Language Interpreter Needed |
| We will book a professional interpreter for you. This might be in person, on the phone or via video, and will always be free of charge. If an interpreter is not available, we may need to rearrange your appointment. Our preference is not to use your family or friends and we will never ask a child under 18 to interpret your consultation | [ ]  ACTION: Add alert detailing language interpreter, with the current date |
|  |  |
| **ACCESS REQUIREMENTS** |  |
| [ ]  | I have difficulty with my **hearing**, and I use: | [ ]  ACTION: Add alert re: all requirements here, include the date added  |
| Hearing Aids [ ]  | Lip Reading [ ]  | Other [ ]  |
| [ ]  | I have difficulty with my **speech**, and I would like the surgery to know: |
|       |
| [ ]  | I have difficulty with my **sight,** and I need information by: |
| Email [ ]  | Large Font Size [ ]  | Other [ ]  |
| [ ]  | I have a **neurodiverse diagnosis** (such as autism or ADHD) or a **learning disability**. I would like the surgery to know that accessing the building or consultation room can be supported by: |
|       |
| I have one of the above access requirements and my preferred **main** contact is by: | [ ]  ACTION: Add detail under Family/Relationship Links in Registration |
| Email [ ]  | Letter [ ]  | Text Message [ ]  | Phone [ ]  |
| In an emergency, is there someone you would like us to call to get a message to you urgently?**Name and contact details:** |       | [ ]  ACTION: Add alert regarding consent for emergencies |
| *(It is your responsibility to update this information if you have a change in circumstances.)* |  |
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| **CARE NEEDS** | **STAFF USE** |
| Do you live alone? | Yes [ ]  | No [ ]  |  |
| Do you consider yourself to be housebound?*(If you are able to leave the house safely with family or friends, or access a taxi on your own, you are not considered housebound)* | Yes [ ]  | No [ ]  | [ ]  CODE: Housebound |
| *If you are experiencing* ***physical or emotional domestic abuse*** *from a family member or partner, your surgery is a safe place. You can book an appointment to discuss this, and we will support you as best as possible. A good source of support is LDAS: liverpooldomesticabuseservice.org.uk* |  |
| Are you a carer for a relative or friend? | Yes [ ]  | No [ ]  | [ ]  CODE: Is a Carer |
| Do you have a relative/friend as your carer? | Yes [ ]  | No [ ]  | [ ]  CODE: Has a Carer |
| Name of Carer: |       | Relationship: |       |  |
| Carer Telephone: |       |  |
| Do you have an agency providing care for you? | Yes [ ]  | No [ ]  | [ ]  ACTION: Add detail under Family/Relationship Links in Registration |
| Name of Agency: |       | Telephone: |  |
| In an emergency, do you consent to us contacting your carer? | Yes [ ]  | No [ ]  | [ ]  ACTION: Add alert regarding consent for emergencies |
| *(It is your responsibility to update this information if you have a change in circumstances.)* |
|  |  |
| **OTHER PERSONAL BACKGROUND** |  |
| Have you ever, or are you currently, serving in the Armed Forces? | Yes [ ]  | No [ ]  |  |
| Are you happy for ‘veteran’ to be recorded on your medical record?*(For some conditions this can be particularly relevant and support any future referrals that might be needed)* | Yes [ ]  | No [ ]  | [ ]  CODE: Military Veteran |
| My preferred pronouns are: | [ ]  He/Him/His | [ ]  She/Her/Hers | [ ]  ACTION: Add alert if differs from typical pronouns |
| [ ]  They/Them/Theirs | [ ]  Other:       |
| My medical record is currently: | Male [ ]  | Female [ ]  |
| [ ]  | I would like to understand more about the process to change my gender marker | [ ]  ACTION: Bring to attention of a clinician |
| *We will always endeavour to follow preferences, but please be patient with our staff if they slip up – we are dealing with thousands of patients, each with individual needs and preferences, and sometimes we may need a gentle prompt. However, if your preference is persistently not recognised, do give us feedback about this so we can investigate it.* |  |
| [ ]  | I have appointed a Lasting Power of Attorney*(You will need to ask them to bring their paperwork – this can be done when/if this becomes relevant)* | Name: |       | [ ]  CODE: Lasting Power of Attorney Personal Welfare |
| [ ]  | I am subject to a Deprivation of Liberty Safeguard or a Liberty Protection Safeguard | [ ]  ACTION: Bring to the attention of the Safeguarding Lead |
| [ ]  | I am subject to a Community Treatment Order |
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| **SUMMARY CARE RECORD** | **STAFF USE** |
| A summary care record contains information about your medication, allergies and adverse reactions, and additional further medical information. There is more detailed information available if you would like to know more about your data use. |  |
| Are you happy for your summary care record to be available when you access NHS care outside of your GP Practice? *(For example, NHS Out of Hours Services or Accident & Emergency)* | Yes [ ]  | No [ ]  | [ ]  CODE: Choose appropriate Summary Care Record code |
| Signature: |       | Date: |       |  |
| Name:(If signing on behalf of a patient or child) |       | Relationship: |       |  |

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