Bedlingtonshire Medical Group Questionnaire

Please complete ALL of this confidential questionnaire.
Please complete in BLOCK CAPITALS and tick the boxes as appropriate.
Please complete a separate form for each family member to be registered.

Full Name:					**Telephone Number:**	
Mr / Mrs / Miss / Ms / Other……..					**Work Number:**	
Address and Postcode:					**Mobile Number:**	
					E-mail Address:	
					Can we contact you by text? Y/N **Can we contact you by email? Y/N**	
					Next of Kin:	
Date of Birth:					**Next of Kin Contact Number:**	
Marital Status:		**Gender:**	**Male:**	**Female:**	**Do you smoke Y/N** **If Yes how many per day:** **If ex smoker when did you stop and how many did you smoke per day:_____** **_____** **If you would like help or advice to stop smoking please contact Northumberland Stop Smoking Service on 01670 813135**	
Occupation:						
Names and Ages of Children:					**Have you served in the armed forces? If Yes please give details:**	
					For women only – Are you pregnant? Y/N	
Your height:	**Feet / inches**		**cm**	**Your weight:**	**Stones / lbs.**	**kg**
Your Religion:	**C of E**	**Catholic**	**Other Christian (state)**		**Buddhist**	**Hindu**	**Muslim**
	Sikh	**Jewish**	**Jehovah's Witness**		**No religion**	**Other religion (state)**	

Your Ethnic Origin: (select one)	**White (UK)**	**White (Irish)**	**White (Other)**
Caribbean	**African**	**Asian**	**Other Mixed Background**
Indian / Brit Indian	**Pakistani / Brit Pakistani**	**Bangladeshi / Brit Bangladeshi**	**Other Asian Background**
Other Black Background	**Chinese**	**Other**	**Ethnic Category not stated**

Your main or 1st language Spoken / Understood: (select one)		English	Hindi	Gujurati	Urdu	Bengali /Sytheti	Punjabi
Polish	Ukrainian	French	German	Spanish	Other: (Please Specify)		

Will you need help in translation during contact with us? Y / N

Alcohol – please tick all of the boxes that apply to you and add up your total score:

How often do you have a drink that contains alcohol?	☐ Never *(0 points)* ☐ Monthly or less *(1 point)* ☐ 2 – 4 times per month *(2 points*) ☐ 2 – 4 times per week *(3 points)* ☐ 4 + times per week *(4 points)*	**How many standard alcoholic drinks do you have on a typical day when you are drinking?**	☐ 1 – 2 *(0 points)* ☐ 3 – 4 *(1 point)* ☐ 5 – 6 *(2 points*) ☐ 7 – 9 *(3 points)* ☐10 + *(4 points)*
How often do you have 6 or more standard drinks on one occasion?	☐ Never *(0 points)* ☐ Monthly or less *(1 point)* ☐ 2 – 4 times per month *(2 points*) ☐ 2 – 4 times per week *(3 points)* ☐ 4 + times per week *(4 points)*	**Total Score**	…….points

Your Medical Background:

What illnesses have you had & when?	
What operations have you had and when?	
Do you have any medical problems at present?	
Please list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency)	
If you wish you can nominate a local chemist for your prescriptions to be sent to.	**Name and location of chemist:**

Are there any serious diseases that affect your parents, brothers or sisters (tick all that apply)	**Diabetes**	**Heart Attack**	**Heart attack under age of 60**	**Bowel Cancer**	
	Breast Cancer		**High Blood Pressure**	**Asthma**	**Stroke**

	Thyroid Disorder	Any other important family illness?

What immunisations have you had? (please tick all that apply)	Diphtheria	Measles	German Measles	Tetanus	Polio	MMR
	Whooping Cough		Pre-school booster	Triple vaccine (Diphtheria, Tetanus & Pertussis) – 3 doses		

Specific Needs: Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:	
Please state any sensory Impairment you have (i.e. speech, hearing, sight):	
Do you need information in braille, large print or easy read?	
Do you need a British Sign Language interpreter or advocate	
Do you need support to lipread or use a hearing aid or communication tool	
Are you an 'assistance dog' user?	
Please state any physical disabilities you have:	
Please state any mental disabilities you have:	
Please state any requirements you have to be able to access the Practice premises	
Please state any allergies and sensitivities you have:	
Please state any religious or cultural needs:	
Are you a carer?	Y/N Who do you care for?
Do you have a carer? If so please state their name / address / phone number and sign here if you wish us to disclose information about your health to your carer.	Carer contact details: Signed: Date:

Do you have a "Living Will" (a statement explaining what medical treatment you would not want in the future)?	Yes / No	*If "Yes", can you please bring a written copy of it to your New Patient Consultation*
Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)?	Yes / No	If "Yes", please state their name / address / phone number/relationship:

Summary Care Records

The NHS Summary Care Record is an electronic record of important information about your health. It will be available to health care staff providing your NHS Care.

Are you happy to have a Summary Care Record?	**Yes**	**No**	

When we refer you to another health professional for care, we need to give them your medical history so they are aware of your health & any medication you are taking.
If for any reason you do not want us to share your medical history, please inform the doctor at the time of referral.

Do you have access to the internet at home? If so and you would like to sign up to our online booking, medication ordering and medication/allergy history please complete the Online Form enclosed in your new patient pack.

Patient Participation Group

The Practice is committed to improving the services we provide to our patients.
To do this, it is vital that we hear from people about their experiences, views, and ideas for making services better.
By expressing your interest, you will be helping us to plan ways of involving patients that suit you.
It will also mean we can keep you informed of opportunities to give your views and keep you up to date with developments within the Practice.
If you are interested in getting involved, please provide your name, email address and contact telephone number and we will pass these details to the group coordinator.

Name:

Email address:

Telephone number:

For more information on our Patient Participation Group please contact Jill Henderson, Patient Services Manager on 01670 536214 email jill.henderson3@nhs.net

Patient signature:		**Signature on behalf of patient:**	
		Name of person signing on behalf of patient.	

Thank you for completing this form

For more information about the services we offer, please see our website: www.bedlingtonshiremedicalgroup.co.uk