Lincoln House Surgery

33 Lincoln Road, Southport, Merseyside, PR8 4PR
Tel: 01704 566277 Fax: 01704 565128 Email: gp.N84037@nhs.net

NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE

To register with the Practice please complete this questionnaire as fully as possible. The information will help the doctor to make an initial assessment of your health which will help in your future treatment.
If you become registered with this practice, your registered GP will be Dr S Shyamsundar.

Surname: ……………………………… Forename(s): ………………………… Date of Birth: …..………………

Marital status: …..………………. Next of Kin Name and Contact Number: ……………………………………..

Address: ……………………………………………………………………………………………………….

……………………………………………………………….………………... Postcode: ………………….……

Home Tel: ………………………………………….…… Mobile: ………………………………………......

Email address: ………………………………………………………………………………………………

Occupation: ……………………………………………………………………………………………………..

Weight (approx): ……………………………………….. Height: ………………………………………..……

Date of completion of this form: ……………………………………………………………………….

CARERS

Do you need / have anyone who looks after you or your daily needs as Carer? Yes / No

If "Yes", would you like them to deal with your health affairs here? Yes / No
(the receptionist can help with these arrangements)

Do you care for anyone else? Yes / No
If "Yes", ask the receptionist about Carers support

What is your ethnic group (please tick the appropriate box)

White British	Other White ethnic group	Black African	Black Caribbean	Indian	Chinese	Black other mixed	Other

WHAT IS YOUR FIRST LANGUAGE (spoken) ………………………………………………………....

WILL YOU REQUIRE HELP FROM AN INTERPRETER WHEN YOU COME TO THE SURGERY
Yes / No

If yes, please give details of the language for which you require interpretation:

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SUMMARY CARE RECORD (SCR) – your emergency care summary

The record will contain information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had to ensure those caring for you have enough information to treat you safely.

Your Summary Care Record will be available to authorised healthcare staff providing your care anywhere in England, but they will ask your permission before they look at it.

This means that if you have an accident or become ill, healthcare staff treating you will have immediate access to important information about your health

Please tick one of the boxes below:

Yes I would like a Summary Care Record ☐

No I do not want a Summary Care Record ☐

MEDICAL HISTORY

Yourself – Do you have any of the following? If "yes" please tick the box and approximate the time since diagnosis

Family – Has any of your family, (mother, father, and sibling) suffered any of the following? If "yes" please tick the box and indicate the age of onset

	Yourself	Family member
Asthma		
Bronchitis/Emphysema		
Cancer		
Diabetes		
Depression		
Epilepsy		
Heart Disease		
High Blood Pressure		
High Cholestrol		
Stroke		

If diabetic, please state how you are treated, ie

Diet alone ....

Diet and medication ....

Diet and insulin ....

PLEASE STATE ANY RELEVANT PAST MEDICAL HISTORY, INCLUDING ANY CONDITION YOU ARE CURRENTLY BEING TREATED FOR AND ANY OPERATONS:

....

....

....

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DO YOU HAVE ANY CURRENT MEDICAL PROBLEMS NOT LISTED THAT REQUIRE A CONSULTATION WITH A GP IN THE NEAR FUTURE?: ....

If **YES**, please list ....

....

....

Do you require transfer or follow up for an ongoing condition to a local hospital. *YES / NO*

....
If yes, give details:-
....

....

Please give dates of any X-ray, MRI or CT scans, Mammogram, Ultrasound
……..

MEDICATION

Please give details of any medication which you take (prescribed or otherwise):

Name of drug: ……………………………………
Dosage: …………………………………………….

Name of drug: ……………………………………
Dosage: …………………………………………….

Name of drug: ……………………………………
Dosage: …………………………………………….

ARE YOU ALLERGIC TO ANY MEDICATION? Yes / No

If **YES,** please give details: ....

ALLERGIES

Are you allergic to any substances or foods? Yes / No

If yes, please give details:
……
……

IMMUNISATIONS

Dates of Triple/Polio/HIB:
……………………………………………………………………………………………..

Dates of MMR:
………………..…………………………………………………………………………………………..

Date of last Tetanus:
………………………………………………………………………………………………………

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FEMALE PATIENTS

Date of most recent cervical smear: …………………………………..
Result of most recent smear: …………………………………………….
Please give details of any complications in pregnancy:
……
……

SMOKING

Do you smoke? Yes / No

If Yes, please give details:

Cigarettes per day: ……….…….. Cigars per day: ………..….. Ounces of tobacco per day: …….……..

How old were you when you started smoking? …………………..

Do you want any advice or help to Stop Smoking? ……………………

EX-SMOKERS

How old were you when you stopped smoking? …………………
How much did you smoke per day? …………………………………..

PASSIVE SMOKING

Are you exposed to smoke at work? Yes / No At home? Yes / No

ALCOHOL

For the following questions please circle the answer which best applies
1 drink = 1/2 pint of beer or one glass of wine or 1 single spirits

Men: How often do you have EIGHT or more drinks on one occasion?
Women: How often do you have SIX or more drinks on one occasion?

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*

How often during the last year have you failed to do what was normally expected of you because of drinking?

Never *Less than monthly* *Monthly* *Weekly* *Daily or Almost Daily*

In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

No *Yes on one occasion* *Yes on more than one occasion*

DIET

Do you add salt to your food after cooking? Yes / No

Do you have a varied diet including milk, meat, vegetables and fruit? Yes / No

Has your Cholesterol been checked in the last 2 years? Yes / No

EXERCISE

Do you take regular exercise? Yes / No

If yes, what sort of exercise? ………………………………………………………………………………

How many times do you partake in exercise per week? …………………………………………………..

Continues on next page >>>>

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ADDITIONAL INFORMATION

IF BORN OUTSIDE UK PLEASE PROVIDE DATE OF ENTRY INTO THIS COUNTRY ....

IF YOU HAVE RECENTLY RETURNED TO THE UK AFTER LIVING ABROAD, PLEASE STATE, IF APPLICABLE:

A) The date of exit from the UK: ....

B) The date of entry back into the UK: ....

IS THIS THE FIRST TIME YOU HAVE REGISTERED WITH A GP IN THE UK? YES / NO ....

IF THE ANSWER TO THE ABOVE QUESTION WAS 'NO' PLEASE PROVIDE YOUR LAST 3 PREVIOUS ADDRESSES

....

....

....

PLEASE LIST THE NAMES AND ADDRESSES OF ANY DOCTORS YOU HAVE BEEN REGISTERED WITHIN THE UK

....

....

....

HAVE YOU TRIED TO REGISTER AT ANY OTHER PRACTICE IN SOUTHPORT: YES / NO

IF YES, WHICH SURGERIES HAVE YOU TRIED ? ....

NB. By giving us your email address and/or mobile telephone number, ,this means that you consent to contact by us via email/mobile phone, including SMS text message, for reasons such as offers of clinic appointments, offers of seasonal flu vaccination, although this is not an exhaustive list.. It is very important, therefore, that you ensure that we have up to date contact details for you at all times.

Declaration:
I have read and understood the statement above, and sign to confirm that I am happy to be contacted by email/SMS text message as and when necessary, for the reasons stated above.

Signed:……..
For Office Use Only: 9NdS.

Thank you for completing this questionnaire. Your doctor will assess the information provided and will invite you for an initial examination, discussion about your health, and general check within the next few days.