Lilliput Surgery New Patient Questionnaire

Welcome to The Lilliput Surgery. To accurately register you at the surgery please **fully complete** this questionnaire and the purple GMS1 form. You must also bring with you photographic proof of ID (e.g. passport or a UK photo driving licence) and proof of residency (e.g. current utility bill, recent bank statement or letter from host family/college). **Please note your registration cannot be accepted until the forms are completed in full, with all requested details and proof of ID and residency**. All information provided is treated in the strictest confidence. Thank You.

PERSONAL DETAILS			
Title		Surname	
Forename		Middle Name(s)	
Date of Birth		NHS Number	
Gender		Marital Status	
Occupation			
Are you a Military Veteran?			
Ethnicity	☐ British ☐ Chinese ☐ Other Asian ☐ Pakistani	☐ African ☐ Indian ☐ Other Black ☐ W&B African	☐ Bangladeshi ☐ Irish ☐ Other Mixed ☐ W&B Caribbean
	☐ Caribbean ☐ Other White ☐ White Asian ☐ Refuse to Divulge		
Main Language			
Interpreter Required?	☐ Yes ☐ No		

HOME ADDRESS			
House Name\Flat Number			
Number & Street			
Locality			
Town			
County			
Postcode		Key Safe Number?	
Name of Workplace / School/ College / University			

CONTACT DETAILS – THESE SHOULD BELONG TO THE PERSON REGISTERED ON THIS FORM, ESPECIALLY MOBILE NUMBERS	
Home Telephone (Preferred Number yes/no)	
Mobile Telephone (Preferred Number yes/no)	
Work Telephone	
Email Address (if happy to receive emails)	

PATIENT CONTACTS	
Next of Kin	
Relationship	
Telephone Number	

Do you have a designated carer? Are they a patient at this surgery? Please provide contact details below:

Name of carer		Contact	

Carers: If you are a carer and would like to be added to the Practice's register to receive regular information and meeting dates please indicate ☐Yes ☐No

I care for (name)	
Relationship to you	

The person I care for has: ☐ Dementia ☐ Chronic Disease ☐ Physical Disability ☐ Learning Disability ☐ Mental Health Problem

Your Medical History: Please list all current or past illnesses/operations including dates where possible:

☐ Heart Disease / Angina ☐ Diabetes ☐ Epilepsy
☐ High Blood Pressure ☐ Stroke/TIA ☐ COPD
☐ Asthma ☐ Cancer ☐ Hypothyroidism
☐ Osteoporosis ☐ Rheumatoid Arthritis ☐ Dementia
☐ High Cholesterol ☐ Other (please state):……..

Family History: Please indicate below if your Father, Mother, Brother or Sister had any of the following before the age of 65

Heart Disease		**Stroke**		**Cancer**	

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Do you have any Allergies? (e.g. antibiotics, food, bee sting, latex,) ☐ YES ☐ NO
If Yes please state:

LADIES: Are you currently Pregnant?	☐ YES	☐ NO
LADIES: If you are pregnant please provide estimated delivery date	Date:	
LADIES: Have you had a hysterectomy?	Date:	

Health Information:

Weight (st\lbs or Kgs)		**Height** (ft\" or metres)		**BP** Attach reading	

Smoking Status: (please tick one box only)
☐ I am a Smoker – Please state how many cigarettes/cigars per day
(If you would like help to stop smoking please ask at reception for information)
☐ I have never smoked | ☐ I am an ex-smoker - Date quit:

How many units of alcohol do you drink per week?……..

Please complete the following questions (Alcohol 'FAST' screening test)

Scoring:	0	1	2	3	4	Totals:
How often do you have 8 (Men) or 6 (Women) or more drinks one occasion?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
Only answer the following questions if your answer above is monthly or less:						
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
Has a relative/friend/doctor/health worker been concerned about your drinking/advised you to cut down?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	

☐ FAST Alcohol screening test declined

For online services – please tick here to be allocated a user name and password ☐Yes please ☐No thanks
Please note you can collect your user name and ID from the surgery one week after your forms are submitted.

Electronic Prescription Service: The practice can send your prescription to your preferred pharmacy electronically. If you have previously nominated a pharmacy in another area and you now wish to change to a local pharmacy, please inform us of your preferred pharmacy here: ……

Would you be interested in joining the Practice Patient Participation Group? ☐Yes ☐No
Do you have any additional communication needs that you need extra help with? ☐Yes ☐No

If any of the details on this form change in the future please inform us. In accordance with the Data Protection Act, the Practice needs consent from any Patient for us to leave a message, send a text or information regarding their medical treatment. By providing the information on this form you are consenting to be contacted about your medical needs. The Lilliput Surgery uses SystmOne Clinical software. This enables us to share your record with other NHS organisations who are involved in your healthcare. To opt out of sharing, or if you wish to opt out of having a Summary Care Record, please speak to the receptionist or advise us in writing.

Name (printed): _____ **Date of Birth**: _____

Signed: _____ **Date**: _____

For surgery use only

Items required for Registration	Receptionist ID	Items required for Registration	Receptionist ID
Photo ID?		Nominated Pharmacy?	
Proof of Address 1?		BP?	
Proof of Address 2?		Is the GMS form signed?	