Bexley Medical Group

King Harold's Way Surgery
171 King Harold's Way
Bexleyheath
Kent DA7 5RF
Tel: 020 8303 1127

Hurst Place Surgery
294a Hurst Place
Bexley
Kent DA5 3LH
Tel: 020 8300 2826

Erith Health Centre
50 Pier Road
Erith
Kent DA8 1RQ
Tel: 01322 334237

NEW PATIENT QUESTIONNAIRE

INTRODUCTION

This document is intended to be completed by patients to provide basic health information.

Name: _____Date of Birth: _____

Gender: Male ☐ Female ☐ NHS Number: _____

Address: _____

_____

Post Code: _____ Email: _____

Tel No Home: _____Work: _____ Mobile: _____

NAME AND ADDRESS OF SCHOOL / COLLEGE (ALL PATIENTS AGED 18 AND UNDER)

Name of School / College: _____

Address: _____

SMOKING STATUS

Never smoked tobacco ☐ Current smoker ☐ Ex-smoker ☐

TOBACCO CONSUMPTION

Cigarettes per day _____ Cigars per day _____ Ounces of tobacco per day _____

EX-SMOKERS

If you used to smoke, when did you start? _____ When did you stop? _____

If you used to smoke, how many did you smoke per day?

Cigarettes per day _____ Cigars per day _____ Ounces of tobacco per day _____

ALCOHOL STATUS

Currently drinks ☐ Lifelong teetotaller ☐ Ex-drinker ☐

IF YOU CURRENTLY DRINK OR ARE AN EX-DRINKER, PLEASE ANSWER THE FOLLOWING

Units of alcohol per day _____ Date started _____ Date stopped _____

Height: _____ **Weight:** _____

EXERCISE

Do you take regular exercise? Yes ☐ No ☐

Please also tick the most relevant box below

Exercise physically impossible ☐	Avoid even trivial exercise ☐	Light exercise ☐
Moderate exercise ☐	Heavy exercise ☐	Competitive athlete ☐

Do you suffer/or have you ever suffered from any of the following?

Heart Attack/Disorder	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Asthma/COPD	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No

Please list below any current or significant past medical history (i.e. hospital admissions):

Are any of your close relatives (mother, father, brother or sister) suffering with/or suffered from any of the following?

Heart Attack/Disorder	☐	Yes	Relationship: _____	☐	No
Stroke	☐	Yes	Relationship: _____	☐	No
Asthma/COPD	☐	Yes	Relationship: _____	☐	No
Diabetes	☐	Yes	Relationship: _____	☐	No
High Blood Pressure	☐	Yes	Relationship: _____	☐	No

Have any of your close relatives died from either of the following?

Heart Attack/Disorder	☐	Yes	☐	No
Stroke	☐	Yes	☐	No

Have you ever been prescribed antidepressants?	☐	Yes	☐	No
Do You suffer from any allergies?	☐	Yes	☐	No

If yes please give details below

CARERS

Are you a carer? ☐ Yes ☐ No

LEARNING DIFFICULTIES

Do you have any learning difficulties? ☐ Yes ☐ No

If yes, please give information

For Nurse use only:

Urine:

Signed……Date……

Please bring this form and a urine sample to your New Patient Check. This will be carried out at the Health Centre by one of our Practice Nurses.

The Accessible Information Standard aims to ensure that patients (or their carers) who have a disability or sensory loss can receive, access and understand information, for example in large print, braille or via email, and professional communication support if they need it, for example from a British Sign Language interpreter.

This applies to patients and their carers who have information and / or communication needs relating to a disability, impairment or sensory loss. It also applies to parents and carers of patients who have such information and / or communication needs, where appropriate.

Individuals most likely to be affected by the Standard include people who are blind or deaf, who have some hearing and / or visual loss, people who are deaf blind and people with a learning disability. However, this list is not exhaustive.

• Do you have communication needs? Yes ☐ No ☐

(If yes please complete the rest of the form. If no there is no need to continue).

• Do you need a format other than standard print? Yes ☐ No ☐

• Do you have any special communication requirements? Yes ☐ No ☐

• How do you prefer to be contacted? …….

• What is your preferred method of communication? …….

• How would you like us to communicate with you? …….

• Can you explain what support would be helpful? …….

• What is the best way to send you information? ……..

• What communication support could we provide for you? ……..……

……

Name: ……. Date of birth: …….

If you have a carer do they need communication assistance? Yes ☐ No ☐

If 'Yes' what is your Main Carer's name: …….

Do you consent to the practice contacting your main carer regarding your care? Yes ☐ No ☐

What is the best way to contact them?.....

Signed: …… Date: ……

Please post or hand this form in to the surgery – thank you.

PATIENT ETHNIC ORIGIN QUESTIONNAIRE

This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act.

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

Choose ONE section from A to E, and then tick ONE box to indicate your background.

First spoken language:

A White

	British
	Irish
	Any other white background please write in below

B Mixed

	White and Black Caribbean
	White and Black African
	White and Asian
	Any other mixed background please write below

C Asian or Asian British

	Indian
	Pakistani
	Bangladeshi
	Any other Asian background please write below

D Black or Black British

	Caribbean
	African
	White and Asian
	Any other black background please write below

E Chinese or other ethnic group

	Chinese
	Any other please write below

FAST QUESTIONNAIRE

Questions	Scoring system					Your score
	0	1	2	3	4	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only answer the following questions if the answer above is Monthly (1) or Less than monthly (2). Stop here if the answer is Never (0), Weekly (3) or Daily (4).						
How often during the last year have you failed to do what was normally expected from you because of your drinking?	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	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
Scoring: A score of 0 on the first question indicates FAST negative A total of 1 – 2 on the first question then continue with the next three questions, if score is 1 – 2 this indicates FAST negative A total of 3 – 4 on the first question stop screening at first question. An overall total score of 3 or above is FAST positive. **A score of 3 – 4 (FAST positive) requires the completion of the Audit (next page)**						**Total**

Score from FAST (first page)

score	

Remaining Audit questions

Questions	**Scoring system**					**Your score**
	0	**1**	**2**	**3**	**4**	
How often do 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 - 8	10+	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
TOTAL AUDIT Score (all 10 questions completed): 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence						**Total**

Bexley Medical Group

Patient Online registration form
Access to GP online services

Surname			
First name			
Date of birth			
Address			
Postcode			
Email address			
Telephone number		Mobile number	

I WISH TO HAVE ACCESS TO THE FOLLOWING ONLINE SERVICES

(TICK ALL THAT APPLY):

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐

If you wish to have online access to your medical records please request the Patient Online registration form, Access to medical records services form from reception.

Signature		Date	

FOR PRACTICE USE ONLY

Identity verified through (tick all that apply)	Vouching ☐ Vouching with information in record ☐ Photo ID ☐ Proof of residence ☐	Name of verifier	Date
Name of person who authorised (if applicable)			Date

Important Information – Please read before returning this form

If you wish to, you can now use the internet to book appointments with a GP, request repeat prescriptions for any medications you take regularly and look at your medical record online. You can also still use the telephone or call in to the surgery for any of these services as well. It's your choice.

It will be your responsibility to keep your login details and password safe and secure. If you know or suspect that your record has been accessed by someone that you have not agreed should see it, then you should change your password immediately.

If you can't do this for some reason, we recommend that you contact the practice so that they can remove online access until you are able to reset your password.