Kirkoswald Surgery
Kirkoswald
Penrith Cumbria CA10 1DQ

☎ 01768 898560

New Patient Health Questionnaire - Adult

Thank you for joining Kirkoswald Surgery. To ensure that we have up to date medical and personal details, please complete this registration form as fully as possible. After completion the questionnaire should be returned to the Surgery.
If you are aged between 40 and 74 and not on a disease register you may be eligible for a NHS Health check, please ask at reception

The information you give us is confidential and is subject to the General Data Protection Regulation (GDPR) Our privacy Policy is enclosed.

Please bring photographic ID and verification of your current address with you when you register.

Surname		Forename(s)	
Date of Birth		Marital Status	
Address			
Postcode			
Home Number		Mobile	
Email Address			
If you have supplied your mobile number, please confirm if you would be happy to receive contact from surgery via text i.e. appointment reminders		Yes/No	
Next of Kin: Relationship:		Address: Phone Number:	

Occupation			
Weight (approx. KG)		Height (approx. CM)	
Do you have any hearing difficulties?		Yes/No	
Do you need an interpreter or sign language support?		Yes/No	

Smoking					
Do you smoke?		Yes/No	If yes, How Many?		
Cigarettes per day		Cigars per day		Ounces of tobacco per day	
How old were you when you started 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 Unit + ½ pint of beer or one glass of wine or 1 single spirit

Please answer all the below questions						
	0	1	2	3	4	Score
How often do you 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	7-9	10+	
Men: How often do you have eight or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Women: How often do you have six or more drinks on one occasion?						
A total of 5+ Indicates hazardous or harmful drinking.						

Exercise	
Do you take regular exercise?	Yes/No
If yes, What sort of exercise?	
How many times per week?	

Family History		
Heart Disease (Heart attacks, angina)	Yes/No	Which Family member?
Stroke?	Yes/No	Which Family member?
Cancer?	Yes/No Site of cancer?	Which Family member?

Allergies	
Are you allergic to any substance or foods?	Yes/No
If yes, Please give details:	

Medication;
Please give details of medication which you take. (prescribed or otherwise) It would be helpful if you have proof of medication such as right hand side of your prescription with items listed.

	Name of drug	Dosage
1		
2		
3		
4		
5		

Past Medical History
Please give details of any hospital treatment as an in-patient:
Please give details of any treatment for any chronic medical conditions:
Please give dates of any X-ray, MRI or CT scans, Mammogram, ultrasound:

Female Patients	
Date of most recent smear?	
Result of most recent smear?	

Please give details of any complications in pregnancy:	

Carers	
Do you need / have anyone who looks after you as a carer?	YES/NO
If yes would you like them to deal with your health affairs here?	YES/NO (if yes please fill out access below)
Do you care for anyone else? If "Yes" are you able to give details.	

Consent for Third Party Access

Due to patient confidentiality, if you would like a family member or friend to be able to discuss your medical records on your behalf, we need your permission to do this so we can record consent onto your records.

Yes/No

If Yes: What is their name including title: Relationship to you:

Their address: Their telephone number:

Are they your next of kin? Y/N
Are they your emergency contact? Y/N

Application for online access to my medical record	
I wish to have access to the following online services (Please tick all that apply)	
Booking Appointments	
Requesting repeat prescriptions	
If you would like access please ask at reception for your personal pin code	
I wish to access my medical record online and understand and agree with each statement (tick)	
I have read and understood the information leaflet provided by the practice	
I will be responsible for the security of the information that I see or download	

If I choose to share my information with anyone else, this is at my own risk	
I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	
If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible.	

TB Screening

Have you recently come to the UK? Including returning to the UK after overseas visits for more than 3 months Yes/No

If Yes, please highlight which countries			
Afghanistan	Columbia	Indonesia	Peru
All African Countries	Croatia	Iraq	Portugal
Sub-Saharan	Africa	Dominican Rep	Kazakhstan
Korea	Argentina	DPR Korea	Latvia
Moldova	Armenia	Djibouti	Lithuania
Romania	Azerbaijan	Ecuador	Malaysia
Russia	Bangladesh	El Salvador	Maldives
Saudi	Belarus	Estonia	Micronesia
Singapore	Bolivia	Georgia	Mongolia
Sri Lanka	Bosnia	Guatemala	Morocco
Thailand	Brazil	Guyana	Nepal
Timor-Leste	Brunei	Haiti	Nicaragua
Ukraine	Cambodia	Honduras	Pakistan
Vietnam	China	India	Paraguay
Other			

If the patient has come from a country with high incidence of TB, make an appointment with the practice nurse. If you do not attend this appointment, we will only be able to register you as a temporary patient.

Non EU Patients – Please provide below information

Passport Number	Visa Date of Issue	Visa Expiry Date

If this information cannot be provided, you will be registered as a temporary patient until the above details are provided.

Thank you for completing this questionnaire

For Practice Use Only

Patient NHS Number		*Practice Computer ID Number*	
Identify Verified by (initials)	*Date*	*Method* *Vouching* *Vouching with information in record* *Photo ID and proof of residence*	
Authorised by			*Date*
Named GP and Patient Informed			

SCR – Summary Care Record
All patients registered with a GP practice in England will have a SCR. This contains key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medication.
This information is shared across different healthcare organisations and systems. Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.
Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care.

You may also consent for 'Additional SCR' – this is the same as above plus information about your illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.

If you would like us to allow the sharing of Additional Information please circle **YES**

If you wish to opt out from a SCR, unfortunately, this can no longer be set by the GP surgery. You can instead record your opt out on line by following the link www.nhs.uk/your-nhs-data-matters
Or by telephoning on 0300 3035678

Please Complete		
Name		
Signature		Date