**Dr Mark Thompson** (MB, ChB, MRCGP, DRCOG, DFFP)
**Dr Claire Graham** (BMBS, MRCGP, DRCOG, DFFP, MRCPCh)
**Dr Claire Freeman** (MBChB, MRCGP, DCH, DRCOG, FSRH)

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**The Old Farm Surgery**
**67 Foxhole Road**
**PAIGNTON**
**Devon**
**TQ3 3TB**

**Tel: 01803 556403**
**Fax: 01803 665588**

# NEW PATIENT MEDICAL CHECK

Welcome to "Old Farm Surgery". In order for us to get to know you better and to help us complete your registration, we would be grateful if you could complete this Registration Questionnaire and the attached purple GMS1 Form and return to us within 2 weeks.

**It will be necessary for you to bring in a form of identification with your current address for verification.**

Once we have received and reviewed this questionnaire, and if we feel we need to see you for blood tests or investigations in relation to any chronic conditions, we will contact you and invite you to the surgery.

Thank you.

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Have you previously been registered here? Yes ☐ No ☐ If so, when? _____

Name _____ Date of Birth _____

Address_____

Postcode _____ Contact Number(s)☎_____

_____

Email Address_____

Family Members _____

Are they registered here? Yes ☐ No ☐ If so, when? _____

Height _____ Weight _____

Cigarettes/Tobacco – Yes ☐ No ☐ If YES number daily ____ How many years smoked?____

Would you be interested in giving up smoking at this time? Yes ☐ No ☐

If you have given up smoking – when? _____

Exercise taken – what type and how much? _____

_____

Allergies _____

_____

Significant Illnesses and date of diagnosis

_____

_____

_____

_____

Operations _____

_____

_____

Family History (i.e. Diabetes/Heart Attack/Strokes/Cancer) and approximate age of diagnosis

_____

_____

Any Disabilities (including Visual or Hearing Impairment or Mobility problems) _____

_____

Current Medication and doses if known

_____

_____

_____

**If you are on Morphine, Gabapentin, Pregabalin, Diazepam or any similar drugs then you will require a medication review as these medications lose their benefit when taken regularly and have harmful and addictive properties. We would aim to agree a plan to reduce and stop this medication.**

Preferred pharmacy (if no preference we will automatically send all prescriptions to our most local pharmacy, Day Lewis on Foxhole Road, unless we hear any different) –

_____

_____

Any recent bloods tests: _____

_____

Any outstanding referrals / blood tests overdue: _____

_____

Other agencies involved with you or your family (e.g. Social Services, Support Worker, Specialist Nurses etc)

_____

_____

Have you ever been a member of the Armed Forces? Yes ☐ No ☐

If yes, please indicate which branch and approximate dates of enrollment _____

_____

Are you a Carer? Yes ☐ No ☐

If yes, who do you care for and what is their relationship to you?

_____

Would you like the contact details for our Carer Support Worker? Yes ☐ No ☐

## Immunisation dates if known:

### Children

Dip / Tet / Polio / Hib / Whooping Cough 1st . . . . . 2nd . . . . . 3rd . . . . . .

Pneumonia _____ MMR _____

Hib / Men C _____ Pre-School Booster _____

### Adults

Tetanus _____ Polio _____

Flu _____ Pneumonia _____

Rubella Status _____

Other Travel Immunisations:

_____

**Women only:**

*Contraception – (if relevant)* _____

*Pregnancy & Childbirth History* _____

_____

*Gestational Diabetes: Yes ☐ No ☐ If so, in which pregnancy?* _____

*Cervical Smear: Last approximate date and any previous treatment required:* _____

*Breast Screening: Last approximate date, if applicable?* _____

_____

**If you are contacted to come to the surgery, please bring a urine sample with you – sample pots are available at reception.**

Any Additional Information:

Thank you, we look forward to meeting you

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Name: _____

Date of Birth: _____

Date Completed: _____

## Alcohol Questionnaire

Please complete this form to help us assess any health issues associated with your alcohol intake.

If your score is 5 or above please complete the questions overleaf as well.

Please add your scores up and hand the form to reception. We will contact you if further action is required. Thank you!

## Audit – C:

| Questions | Scoring system | | | | | Your score |
|---|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 | |
| 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+ | |
| 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 | |

**Scoring:**
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

**Audit:**

| Questions | Scoring system | | | | | Your score |
|---|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 | |
| 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+ | |
| 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 | |
| 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 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 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 | |
| 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 | |
| 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 | |
| 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:** 0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 Higher risk, 20+ Possible dependence

**IF YOU WOULD LIKE TO RECEIVE DETAILS OF SPECIAL HEALTH PROMOTION EVENTS AND APPOINTMENT REMINDERS BY TEXT MESSAGE, PLEASE COMPLETE THE CONSENT FORM BELOW**

## PATIENT CARE TEXT MESSAGING

## CONSENT FORM

**Declaration**

I consent to the practice contacting me by text message for the purposes of health promotion and for appointment reminders.

I acknowledge that appointment reminders by text are an additional service and that these may not take place on all / or on any occasion, and that the responsibility of attending appointments or cancelling them still rests with me. I can cancel the text message facility at any time.

The surgery **DOES NOT** offer a reply facility to enable patient to respond to texts directly.

Text messages are generated using a secure facility however I understand that they are transmitted over a public network onto a personal telephone and as such may not be secure, however the practice will not transmit any information which would enable an individual patient to be identified.

I agree to advise the practice if my mobile number changes or if this is no longer in my possession.

**Patient name (PLEASE PRINT) . . . . . Date of Birth . . . . . .**

**MOBILE NUMBER: . . . . . .**

**SIGNATURE: . . . . . Date . . . . . .**

*The practice does not share mobile phone contact details with any external organisation.*

**ETHNIC CATEGORIES:** The government wishes us to collect this information. Please tick the appropriate box. Thank you

| | | | |
|---|---|---|---|
| **White** | British ☐ | Irish ☐ | Any other white background ☐ |
| **Mixed** | White & Black Caribbean ☐ | White & Black African ☐ | Any other mixed background ☐ |
| **Asian or Asian British** | Indian ☐ | Pakistani ☐ | Bangladeshi ☐ Any other Asian background ☐ |
| **Black or Black British** | Caribbean ☐ | African ☐ | Any other black background ☐ |
| **Other Ethnic Groups** | Chinese ☐ | | Any other ethnic group ☐ |

**I do not wish to indicate my ethnic group ☐** **Not known ☐**

**First Spoken Language:**
**What is your first spoken language:** English ☐ Other ☐

Summary Care Records

Torbay NHS Care Trust

Your emergency care summary

Your Name:

Date of Birth:

NHS Number (if known):

---

Old Farm Surgery offers its patients the choice of having a Summary Care Record.

The new NHS Summary Care Record has been introduced to help deliver better and safer c and give you more choice about who you share your healthcare information with.

## What is the NHS Summary Care Record?

The Summary Care Record contains basic information about:

- **any allergies you may have,**
- **unexpected reactions to medications, and**
- **any prescriptions you have recently received**.

The intention is to help clinicians in A & E Departments and 'Out of Hours' health services to give you safe, timely and effective treatment. Clinicians will only be allowed to access your record if they are authorised to do so and, even then, only if you give your express permission. You will be asked if healthcare staff can look at your Summary Care Record every time they need to, unless it is an emergency, for instance if you are unconscious. You can refuse if you think access is unnecessary.

Over time, health professionals treating you may add details about any health problems and summaries of your care. Every time further information is added to your record, you will be asked if you agree.

## Children under the age of 16

Patients under 16 years will not receive this form, but will have a Summary Care Record created for them unless their GP surgery is advised otherwise. **If you are the parent or guardian of a child then please either make this information available to them or decide and act on their behalf. Ask the surgery for additional forms if you want to opt them out.**

---

- If you are happy for a Summary Care Record to be set up for you then you need take no further action.
- If you want to opt-out now please tick the box below and return it to Reception as soon as possible.

---

**Please tick the box and sign below if you do not want a Summary Care Record:**

**No** I do not want a Summary Care Record ☐

Signed: _____ Date: _____

***Hand this form in at the Surgery if you wish to "Opt-Out***

**For more information visit www.nhscarerecords.nhs.uk or call 0300 123 3020.**

# How do you communicate?

Do you need information in a different way?
If so, please tick what you need below

| | |
|---|---|
| Braille | |
| British Sign Language | |
| Easy read | |
| Email or text | |
| Large print | |
| Other support – please explain here: | |

Please hand to a member of staff or put in the prescriptions box or suggestions box