## Broughshane Medical Practice

## New Patient Questionnaire

Please answer the following questions as fully as you can, this will help us in treating you whilst waiting for your medical records. It is necessary for each member of the family to complete a questionnaire prior to registration. All answers will be treated in strictest confidence.

Visit our website [www.broughshanemedicalpractice.co.uk](http://www.broughshanemedicalpractice.co.uk) for all other information and check out our Practice eBooklet, which is now available to download, print or view.

**Patient Details**

**Title:** Mr / Mrs / Miss / Ms

**Surname: Maiden Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Forename: Other Names: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: / /**

**Address:**

**Postcode:**

**Home Tel: Work Tel \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ID Presented:** YES / NO

**Town & Country of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Consent**

**As a practice we are moving to more online/automated services therefore we request that you consent to receive the following using a mobile number and or email address unique to yourself:**

I consent to SMS Text messages to the following mobile number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES / NO

I consent to be emailed to the following email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES / NO

If you provide the appropriate consent we will be in contact in the near future to sign you up for online access services which allows ordering of repeat prescriptions and booking some appointments.

***(It is your responsibility to update us with any change of contact number in the future)***

**Immunisations**

**Date of last:** Tetanus \_\_\_\_\_\_\_\_\_\_\_\_ Polio Vaccination \_\_\_\_\_\_\_\_\_\_\_\_ Influenza\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

**To help ensure continuity of care for your medication prescribing it would be beneficial for you to provide an up to date medication list from your previous practice. In some cases this information is available as part of your Elective Care Record online and the practice reserves the right to access this if required.**

**Do you have any of the following conditions?**

|  |  |  |  |
| --- | --- | --- | --- |
| **Condition** | **YES / NO** | **Approx. diagnosis date** | **Type where applicable** |
| Asthma |  |  |  |
| COPD |  |  |  |
| Diabetes |  |  |  |
| Atrial Fibrillation |  |  |  |
| Hypertension |  |  |  |
| Heart Disease |  |  |  |
| Kidney Disease |  |  |  |
| Stroke |  |  |  |
| Dementia |  |  |  |
| Thyroid Disease |  |  |  |
| Cancer |  |  |  |
| Other – |  |  |  |

**Have you had any serious illness, operations or stays in hospital (Please give brief details with dates) \_\_\_\_\_\_\_**

**Are you at present undergoing any medical investigations or awaiting any surgical operations? \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have any of your close relatives had important illnesses, e.g. diabetes, high blood pressure, mental illness, heart problems, stroke, cancer etc.? \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergies**

**Do you have any allergies, e.g. Penicillin, pollen, Elastoplast?**

**Health Status**

**Do you smoke?** YES / NO

**If YES, how many do you smoke per day?**

**How long have you been smoking for?**

**Do you smoke:** Cigarettes Roll your own Liquid Nicotine

**Height** \_\_\_\_\_\_\_\_\_\_\_\_\_ **Weight**\_\_\_\_\_\_\_\_\_\_\_\_ **Blood Pressure** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Accommodation** **(Only** **For patients in Nursing Home/Residential Home/Fold)**

**Is your accommodation:** Nursing Home Residential Home Fold

**Do you live on your own?** YES / NO

**Do you have a carer?**  YES / NO

**Other Information**

**Is there any other information you feel is relevant? \_\_\_\_\_\_\_\_**

**Carer’s**

**If you are a carer please ask reception for a Carer’s form to complete**

**Who is a Carer?**

A carer is a person of any age, adult or child, who provides care and support to a partner, child, relative, or friend who couldn’t manage to live independently or whose health or well-being would deteriorate without this help.

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**This Section is for Completion for Females Only**

**Have you had a cervical smear?** YES / NO

If YES, when & where

**Have any previous smears been abnormal?** YES / NO

If YES give date

**What contraception are you using at present?** Condom / IUCD / Implant / None

Or **Pill:** please state which one

**Other:**

**Have you had a hysterectomy?** YES / NO

If YES, when

**Have you had a mammogram?** YES/NO

If YES, when

& where

**Please sign this declaration**

**I have completed this form to the best of my knowledge Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_**

**Broughshane Medical Practice Medication Policy**

The drugs listed below can be dangerous long-term. Practice policy is to reduce these drugs through a reduction programme.

\*\*Diazepam, Temazepam, Nitrazepam, Lorazepam, Zopiclone, Dihydrocodeine, Codeine, Morphine, Fentanyl and any other opiates\*\* Pregabalin (Lyrica is no longer recommended for prescribing in Northern Ireland.

**If you are currently being prescribed any of these drugs please sign below that you are prepared to consent to a reduction strategy in the future.**

* I have read an understood the Practice Policy on these drugs and I agree to a reduction programme when recommended by the GP.
* I understand that any current reduction programme for medications above will continue as planned.
* I do not take any of the above medication.

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Under no circumstances will the practice replace lost or stolen scripts or medication.**

**Please note: We are a non-substitute prescribing practice, if you are currently on substitute prescribing medications you will have to attend the addictions service for your substitute prescribing prescriptions i.e., Methadone, Subutex etc.**