## 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: Email:**

**Home Tel: Mobile:**

**Work Tel:**

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

**ID Presented:** YES / NO

**Town & Country of Birth:**

**Do you consent for us to contact you by text or email?** YES / NO 

**-** You will automatically be enrolled for online access. Please tick the box if you do **NOT** wish to be enrolled.

**Immunisations**

**Date of last:** Tetanus Polio Vaccination

Influenza

**Medical History**

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

**Please list any tablets, medicines or inhalers that you are currently prescribed, including their doses:**

**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?**

**Smoking 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

**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?**

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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

# Are you a Carer? If so, Please fill out the form below:

# Patient Details

**Name:**

**Address:**

**Telephone No:**

• I hereby give permission for the information below to be recorded in my medical notes.

• I give permission for information about my illness/treatment to be shared with my carer.

**Signature:**

**Date:**

# Carer Details

**Name:**

**Address:**

**Telephone No:**

• I hereby give permission for this information to be recorded in the medical notes of the above patient.

• I will keep confidential all information shared with me about the treatment/medication for the patient named above.

**Signature:**

**Date**:

**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.

**Key roles for primary care staff include;**

Identifying patients who are carers

Checking carers physical and emotional health

Informing carers that they can ask Social Services for an assessment of their own need.

Directing carers to other sources of support.

Asking their permission to hold this information on the computer

Permission form to be signed and scanned into the patient notes.

We have enclosed a form for this information to be made available to the practice. If you are happy to share this information with us please complete the attached form and return it to the practice.

**Useful websites**

[www.carersonline.org.uk](http://www.carersonline.org.uk)

[www.carers.org](http://www.carers.org)

**Practice Email (this email is NOT to be used for contacting the Surgery about your medical needs or to order Medication).**

reception.z00317@gp.hscni.net

**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.**