## Chadsfield Medical Practice
## NEW PATIENT MEDICAL QUESTIONNAIRE

NHS Stockport

**Welcome to Chadsfield Medical Practice**

To register with this practice, please complete this questionnaire as fully as possible. The questions have been designed to help your new GP get to know you and your medical history whilst your medical records are being transferred to us. The information you give will help us to provide you with good medical care.

**PLEASE ALSO COMPLETE AND RETURN THE COMPLETED GMS1 FORM**

**PERSONAL DETAILS:**

**Title** …… **First Names(s)** …… **Surname** ……

**Address** ……

…… **Postcode** ……

**Date of birth** …… **Occupation** ……

**Have you been registered here before?** YES ☐ NO ☐

**What is your Ethnic Group**

White ☐ Mixed ☐

Asian, Asian British ☐ Chinese ☐

Black, Black British ☐ Any other ☐ Please specify ……

| **Home Telephone number** | **Mobile Telephone number** | **Work Telephone number** |
|---|---|---|
| | | |

**Text Messaging**

We send text message appointment reminders, blood results and other notices by text.
Please tick the box if you DO NOT wish to benefit from this service: ☐

**Email Address**

Please tick the box if you DO NOT want us to communicate with you via email ☐

**Online Services**

The surgery offers an online service for **booking GP appointments**, **ordering repeat medication**, **viewing medical records** and **updating contact details**. You need to be registered in order to access this service. You can only apply for yourself and must be aged 16 or over. If under the age of 16, then parental consent must be obtained.

Do you want to register for online services? YES ☐ NO ☐

Declaration: Please supply me with my User Name and Password details to allow me to access the online appointment booking and repeat medication ordering services. I understand that I am responsible for securing these details to prevent unauthorised persons from accessing my record online. In the event that my security details have been compromised I will inform the Practice immediately so that access can be blocked and a new password issued. If at any time I wish to permanently cease internet access I will inform the practice in writing.

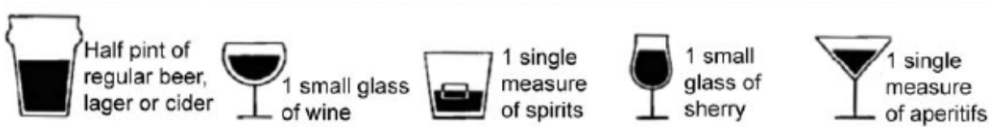
Signature Patient/Parent/Guardian _____ Date _____

| | |
|---|---|
| **Are you a carer? -** *Do you provide care for someone because of their poor health or disability?* Please tell us the name and contact details of the person **you** look after and their relationship to you. | |
| **Are you cared for? -** *Do you need someone to care for you because of your poor health or disability?* Please tell us the name and contact details of the person who looks after **you** and their relationship to you. | |
| **Are you registered disabled?** | YES ☐ NO ☐ |
| **Are you housebound?** | YES ☐ NO ☐ |
| **Would you like to join our virtual Patient Participation Group?** | YES ☐ please add me to your group email distribution list. |
| **Electronic Prescription Service**<br>You can opt for prescriptions to be sent directly to a pharmacy of your choice.<br>Please select a pharmacy. | *(select one only)*<br>Lloyds, Chichester Rd ☐ Lloyds, Woodley ☐ If other, please specify<br>Co-op, Stockport Rd ☐ Medichem, Woodley ☐ ……<br>Cohens, Bents Lane ☐ Other ☐ …… |
| **Please list your medication or attach a copy of your prescription** | |
| **Summary Care Record** | Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information. If you are happy for your information to be used in this way you do not have to do anything. If you wish to prevent this from happening please ask at reception for a Summary Care Record Opt Out form. |

**HEALTH QUESTIONS:**

| | |
|---|---|
| **Do you have any allergies?** | YES ☐ NO ☐ If yes, please state …… |
| **Do you smoke?** | YES ☐ If yes, how many cigarettes a day? ……<br>NO ☐ EX-SMOKER ☐ |
| **Would you like support to stop smoking?** | YES ☐ NO ☐ |
| **How much do you weigh?** | |
| **How tall are you?** | |
| **What is your blood pressure?** | ☐ *If you do not have a recent BP result, please use the machine in the waiting room.* |
| **Do you suffer from any of the following?** | ASTHMA ☐ STROKE ☐ HEART DISEASE ☐ MENTAL HEALTH ☐<br>COPD ☐ DIABETES ☐ STROKE ☐ DEPRESSION ☐<br>CANCER ☐ EPILEPSY ☐ HIGH BLOOD PRESSURE ☐ OTHER ☐ |
| **Is there family history of any of the conditions mentioned above? If yes, please provide some details** | |

**HEALTH QUESTIONS (continued):**

| **Alcohol consumption** | **This is one unit of alcohol:**<br>  <br> |
|---|---|
| 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 (0) ☐ WEEKLY (3) ☐<br>LESS THAN MONTHLY (1) ☐ DAILY/ALMOST DAILY (4) ☐<br>MONTHLY (2) ☐ |
| **Only answer the following questions if the answer above is Never, Less than monthly or Monthly.**<br>**<u>Stop here if the answer is Weekly or Daily.</u>** | |
| How often during the last year have you failed to do what was normally expected from you because of your drinking? | NEVER (0) ☐ WEEKLY (3) ☐<br>LESS THAN MONTHLY (1) ☐ DAILY/ALMOST DAILY (4) ☐<br>MONTHLY (2) ☐ |
| How often during the last year have you been unable to remember what happened the night before because you had been drinking? | NEVER (0) ☐ WEEKLY (3) ☐<br>LESS THAN MONTHLY (1) ☐ DAILY/ALMOST DAILY (4) ☐<br>MONTHLY (2) ☐ |
| Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down? | NEVER (0) ☐ WEEKLY (3) ☐<br>LESS THAN MONTHLY (1) ☐ DAILY/ALMOST DAILY (4) ☐<br>MONTHLY (2) ☐ |

**FEMALE PATIENTS ONLY:**

| | |
|---|---|
| **Are you currently pregnant?** | YES ☐ NO ☐ |
| **Result of your last smear?** | Normal ☐ Abnormal ☐ |
| **Please provide details of your current contraceptive method (if any)** | |

**<u>For Administrative Use Only</u>**

I confirm that I have checked the patient's ID.

**Name:** **Signed:** **Date:**