Official Use Only	Action	Department	Date	Initials
	Action ID Verification on SystmOne	Reception		
	Create Online Account - SystmOne	Reception		
	Scanned onto Patient Notes	Reception		

East Norwich Medical Partnership

OneNorwich
Your Norwich Your Health

New Patient Questionnaire

Welcome to the East Norwich Medical Partnership. We would be grateful if you could fill in this questionnaire, which allows us to ascertain any essential me information in advance of the arrival of your records from your former GP, which can take up to three months.

Patient Details

Surname: **Forename(s):**

Date of Birth:

☎ Home Mobile: Work:

Identification

Please provide the 2 forms of identification below, **all forms of ID will be verified by Duty Receptionist**

Photo ID: Passport / Driving Licence etc. **Type of Photo ID:** Initials:

Utility Bill/Bank Statement something with an Address on it. **Type of ID (Address):** Initials:

Patient under the age of 18 - Birth Certificate: ☐

Consent to Text/ SMS Messages

We can now send you appointment confirmation messages and reminders by text message. If you wish to receive these text messages please read the disclaimer below then complete and sign the slip below.

- I consent to East Norwich Medical Partnership contacting me by text message for the purposes of health promotion, results (in the future) and for appointment reminders.
- I agree to advise the practice if my mobile number changes or if this is no longer in my possession.

Mobile Number:

Background Details

Next of Kin:

Name & Relationship: ( ) Telephone No:

Address:

Power of Attorney:

If you have nominated someone to speak on your behalf please provide documentary evidence as well as providing their details below.

Name & Relationship: ( ) Telephone No:

Address:

Marital Status: Please specify: Single ☐ Married ☐ Co-Habiting ☐ Divorced ☐ Widow(er) ☐

Ethnicity:

Please specify:

White
British ☐
Irish ☐
*Any other White background** ☐

Asian or Asian British
Indian ☐
Pakistani ☐
Bangladeshi ☐
*Any other Asian background** ☐

Chinese or other ethnic group
Chinese ☐
*Any other ethnic group** ☐

Mixed
White and Black Caribbean ☐
White and Black African ☐
White and Asian ☐
*Any other Mixed background** ☐

Black or Black British
Caribbean ☐
African ☐
*Any other Black background** ☐

Religion:

Care Home Resident: Yes ☐ No ☐

Employment:

Military Veteran: Yes ☐ No ☐

Communication

Language:

Do you require an Interpreter? *Yes / No

Do you require a Signing Interpreter? *Yes / No

Carer

Are you a Carer? *Yes / No If yes please provide name:

Do you have a Carer? *Yes / No If yes please provide name:

Medical History

Have you or other family members suffered from any of the following, please tick.

Diagnosis	You	Family Member (Include Age at Diagnosis)	Relationship
Heart Problems		Age:	
Stroke		Age:	
High Blood Pressure		Age:	
Diabetes		Age:	
Glaucoma		Age:	
Cancer		Age:	
Epilepsy		Age:	
Asthma		Age:	

Medications & Allergies

Do you take regular Medication? *Yes/No. If so please list below:

Do you have any allergies? If yes please state:

Lifestyle

Alcohol Audit:

- How often do you have a drink containing Alcohol?
  - Never ☐
  - Monthly or less ☐
  - 2 – 4 times a month ☐
  - 2 – 3 times a week ☐
  - 4 or more time a week ☐

- How many units of alcohol do you drink on a typical day when you are drinking?
  - 1 or 2 ☐
  - 3 or 4 ☐
  - 5 or 6 ☐
  - 7 or 9 ☐
  - 10 or more ☐

- 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 a month ☐
  - Monthly ☐
  - Weekly ☐
  - Daily or almost daily ☐

Smoking:

Current: ☐ **Ex:** ☐ **Never:** ☐

e-Cigarette: **Current:** ☐ **Ex:** ☐

Height: _____ **Weight:** _____

Further Details

Dispensing – EPS / Electronic Prescription Service

Please indicate which pharmacy/location you wish to collect your prescription from: _____

If you collect repeat prescriptions you will not have to visit your GP practice just to pick up your paper prescription. Instead, your GP will send the prescription electronically to the place you choose, saving you time.

Sharing Records

Before answering the questions below please take time to read the information pages on **Sharing Your Medical Informatior** provided:

Sharing Out

Do you consent to the sharing of data recorded here at the East Norwich Medical Partnership with any other organisations tha may care for you?

Yes: ☐ **No:** ☐

Sharing In

Do you consent to the viewing of data by the East Norwich Medical Partnership that is recorded at other care services that may care for you?

Yes: ☐ **No:** ☐

Sign & Date

Thank you for completing this questionnaire, please sign and date below.

Name: **Signature:** **Date:**

All information is strictly private and confidential.