1.

2. GRANGE MEDICAL GROUP

3. NEW PATIENT QUESTIONNAIRE

TO BE COMPLETED FOR ALL PATIENTS AGED 16 YEARS AND OVER

TITLE: Mr/Mrs/Miss/Ms/Other (please specify) ……

FIRST NAME…… SURNAME …….

PREVIOUS SURNAME…….

ADDRESS……

DATE OF BIRTH ……. TELEPHONE: Home……
Mobile…….

PLACE OF BIRTH……...NATIONALITY……

MARITAL STATUS ……. OCCUPATION……

NEXT OF KIN ……

TELEPHONE: Home…… Mobile:…….

RELATIONSHIP TO PATIENT……. …….

HAVE YOU BEEN REGISTERED WITH THE GRANGE MEDICAL GROUP PREVIOUSLY? YES/NO

REGISTERING FOR THE FIRST TIME IN THE UK

DATE OF ENTRY INTO UK……LENGTH OF STAY……

REASON FOR STAY…….…….

What is your: Height……..Weight……

Do you smoke? YES/NO

If so, how much do you smoke? …….……
Have you ever smoked? YES/NO

Five-shot Alcohol Questionnaire (please circle your answers)

1. How often do you have a drink containing alcohol?
(0.0) Never
(0.5) Monthly or less
(1.0) Two to four times a month
(1.5) Two to three times a week
(2.0) Four or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
(0.0) 1 or 2
(0.5) 3 or 4
(1.0) 5 or 6
(1.5) 7 to 9
(2.0) 10 or more

3. Have people annoyed you by criticizing your drinking?
(0.0) No
(1.0) Yes

4. Have you ever felt bad or guilty about your drinking?
(0.0) No
(1.0) Yes

5. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?
(0.0) No
(1.0) Yes

Have you had any illnesses or operations? YES/NO
Please list below:-

Date (Approx.)	Illness/Operation

Are you allergic to any medications? YES/NO

If so, to what? ……

Do you take any regular medication? YES/NO
Please list below **and bring any regular medication to your New Patient Check appointment**:-

Drug	Dose	How Many Times A Day

Preferred Pharmacy: Even if you do not take regular medication, please provide us with the name of a local chemist where you will collect any prescriptions from (e.g. antibiotics) ……

Carer

Do you have a carer? YES / NO
If yes, who is your carer?

Name…… Relationship…….

Telephone…….

Are you a carer? YES / NO
If yes, who do you care for?

Name……...Relationship……

Telephone……

Family History

Do any of your family or close relatives have any of the following conditions?

Condition	YES/NO	Please Give Details
Diabetes		
Heart Disease		
Stroke		
Asthma		
High Blood Pressure		
Cancer (**please specify type**)		
Glaucoma		
Epilepsy		

Women Only

Have you ever been pregnant? YES/NO
If yes, how many children have you had? ……
Have you had any miscarriages or terminations? YES/NO

When did you last have a smear test (if ever)? ……
Where? ……..…….
If taken abroad, we will need a copy of your last smear result. Otherwise you will be required to attend the Practice for a smear test.

Do you use any form of contraception? YES/NO
If yes, what do you use?
……..…

Do you know if you are immune to rubella (German measles) ? (Vaccination does not necessarily mean immunity. Needs to be confirmed by blood test.)
Immune / Not Immune / Do not Know

Patient Statement:

I have completed this questionnaire to the best of my knowledge

Signature……

Date completed ……..

Name: _____ Date of Birth _____

What is your ethnic group? Chose ONE section from A to E then tick the appropriate box to indicate your ethnic group.

A: White

- ☐ British
- ☐ Irish
- ☐ Any other White background, please state _____

B: Mixed

- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian
- ☐ Any other mixed background, please state _____

C: Asian or Asian British

- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Chinese
- ☐ Any other Asian background, please state _____

D: Black or Black British

- ☐ Caribbean
- ☐ African
- ☐ Any other Black background, please state _____

- ☐ **Not Stated/Do Not Wish to Answer**

DO YOU REQUIRE AN INTERPRETER? YES/NO

If YES, what language?_____

GRANGE MEDICAL GROUP
Patient Text Messaging Service

In line with **General Data Protection Regulation (GDPR)** we are currently updating our Data Protection Notice. As part of this process in order to continue communicating with you by text message (for appointment reminders and disease recall etc) we are required to **obtain your consent** and to **ensure our records are kept up to date.**

We would be grateful if you would take a moment to complete this slip.
Please note that the age of consent (for processing personal data) for a child with capacity is 12 years old.

I consent to text messaging for appointment reminders/ recalls: YES NO
(Please circle)

I am aware that I may withdraw consent at any time: YES

NAME	
DATE OF BIRTH	
MOBILE TELEPHONE NUMBER	

Grange Medical Practice

Application for Online Access (for requesting prescriptions)

Surname	Date of birth
First name	
Address Postcode	Telephone number
Preferred Email address (must be a personal email address and not shared with another person):	
Preferred Mobile number (If you have consented to the use of your mobile for patient text reminders we will send a text to this number once your online account has been set up)	

I wish to have access to the following online services

1. Requesting repeat and/or acute prescriptions	YES ☐

I wish to use Online Services. Please read each statement carefully and tick before signing.

I have understood the information provided by the practice	☐
2. I will be responsible for the security of the information that I see or download	☐
3. If I choose to share my information with anyone else, this is at my own risk	☐
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	☐

I understand and agree with all the above statements and consent to the use of my email address for the purpose of setting up an online prescription services account. I am aware that I can update this information or withdraw my consent at any time.

Our Privacy Policy can be found on our website https://www.grangemedicalgroup.com/privacy-policy

Signature	Date

For practice use only

Patient CHI number		Vision ID number	
Identity verified by (initials)	Date	Method Vouching with information in record ☐ **Photo ID and proof of residence ☐**	
Authorised by:		**(#91B)**	Date
Date account created		Date registration letter/email sent	
Scanned to notes **Y/N**			
Consent given for text messaging **Y/N**		Verified by	