# Steyning Health Centre New Patient Form

Dr Noren & Partners

Welcome to Steyning Health Centre

We are sorry that this form may seem a little daunting but we would be grateful if you would complete it carefully as it will provide us with a lot of useful information to be able to treat you until your medical history is forwarded.

**Allocated GP:** *For Office use: Read Code 67DJ / 9NN60*

## 1. Personal details

**Please complete in black ink**

| | | | | | |
|---|---|---|---|---|---|
| First names | | Surname | | | |
| Date of Birth | | Previous Surname | | | |
| Title | | Ethnic Origin | | Language | |
| Address | | | | | |
| Post Code | | Key Safe No. | | | |
| Home Tel No | | Work Tel No | | | |
| Mobile Tel No | | | | | |
| Email address | | | | | |
| NHS Number | | Occupation | | | |

## 2. Consent

| | | |
|---|---|---|
| Telephone: Landline | I give consent to my surgery leaving a message with a third party or on my voicemail requesting that I make contact with the practice | **Yes / No** |
| Mobile Telephone | I give consent to the surgery sending me a text message or leaving a voicemail | **Yes / No** |
| I give consent to the surgery emailing me | | **Yes / No** |

## 3. Relationships

| | |
|---|---|
| **Marital Status** | Single / Married / Divorced / Living with Partner / Widowed |

| | | | |
|---|---|---|---|
| **Next of Kin** | | Please state Relationship | |
| Address | | | |
| Tel No | | | |

| | | | |
|---|---|---|---|
| **Are you a Carer**? | **Yes / No** | For Whom? | |
| Address | | | |
| Are they registered at this practice? | **Yes / No** | Please ensure the person you care for has given their written consent for us to discuss their condition with yourself | |

## 4. Relationships (Continued)

| | | | |
|---|---|---|---|
| **Do you have a Spouse, Partner or Carer** etc. with whom you would like **us** to be able to discuss your past or future medical problems? **Yes / No** | | Please state relationship | |
| Name of above | | | |
| Address | | | |
| Are they registered at this practice? | **Yes / No** | Please sign here to give us consent for us to discuss your medical condition with them | |
| Tel No | | Signature | |

## 5. Present Illness / operations / Impairment

| **Problem** | **Date of Onset (approx.)** | **Problem** | **Date of Onset (approx.)** |
|---|---|---|---|
| ☐ **Asthma** | | ☐ **Chronic Kidney Disease** | |
| ☐ **Cancer** | | ☐ **Chronic Obstructive Pulmonary Disease** | |
| ☐ **Diabetes** | | ☐ **Epilepsy** | |
| ☐ **Heart Disease** | | ☐ **On Treatment for high Blood Pressure** | |
| ☐ **Stroke** | | ☐ **Mental Health Problems** | |
| ☐ **Thyroid Disease** | | ☐ **Learning Difficulty** | |
| **Please complete any other past medical history and if possible please provide the approx. date.** | | | |

**Do you have any communication/information needs relating to disability, impairment or sensory loss, if so what are they: (e.g. Deafness, Blindness etc)**

**Please advise us of any family history of the illness etc mentioned above**

## 6. Medication

**Please list all medication you are taking currently and include a repeat prescription slip, please.**

| Medication | Dose | Times per day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## 7. Prescriptions / Medication – Prescriptions may now be sent to your chosen Pharmacy electronically

| **When requesting your prescriptions would you like to pick up your prescription from the Health Centre?** | | | | | |
|---|---|---|---|---|---|
| **or collect your medication direct from (You may change your nomination at any time)?** | | | | | |
| Paydens, Steyning | | Upper Beeding Pharmacy | | Ashington Pharmacy | |
| If you would like to nominate a different Pharmacy elsewhere in England please provide the full address: | | | | | |

## 8. Allergies

**Do you have any allergies? Yes / No**

**Details and nature of the reaction:**

**9. Exercise**

**General Practice Physical Activity Questionnaire (GPPAQ)***

**Please tell us the type and amount of physical activity involved in your work. Please tick one box that is closest to your present work from the following five possibilities:**

| | | Please mark one box only |
|---|---|---|
| A | I am not in employment (e.g. retired, retired for health reasons, unemployed, full-time carer etc.) | |
| B | I spend most of my time at work sitting (such as in an office) | |
| C | I spend most of my time at work standing or walking. However, my work does not require much intense physical effort (e.g. shop assistant, hairdresser, security guard, childminder, etc.) | |
| D | My work involves definite physical effort including handling of heavy objects and use of tools (e.g. plumber, electrician, carpenter, cleaner, hospital nurse, gardener, postal delivery workers etc.) | |
| E | My work involves vigorous physical activity including handling of very heavy objects (e.g. scaffolder, construction worker, refuse collector, etc.) | |

**During the last week, how many hours did you spend on each of the following activities?**

**Please answer whether you are in employment or not**

| | | None | Some but less than 1 hour | 1 hour but less than 3 hours | 3 hours or more |
|---|---|---|---|---|---|
| a | Physical exercise such as swimming, jogging, aerobics, football, tennis, gym workout etc. | | | | |
| b | Cycling, including cycling to work and during leisure time | | | | |
| c | Walking, including walking to work, shopping, for pleasure etc. | | | | |
| d | Housework/Childcare | | | | |
| e | Gardening/DIY | | | | |

**How would you describe your usual walking pace? Please mark one box only.**

| | | | |
|---|---|---|---|
| Slow pace (i.e. less than 3 mph) | | Steady average pace | |
| Brisk pace | | Fast pace (i.e. over 4mph) | |

## 10. Height and Weight

**Height** ..... **Weight** .....

If you do not know your height and weight there is a machine in the first floor waiting room

## 11. Smoking: Are you?

A smoker ☐ Ex Smoker ☐ Never smoked ☐

**If you smoke are you a?** Cigarette smoker ☐ Pipe smoker ☐ Cigar smoker ☐

If you are an ex-smoker in which year did you give up? .....

If you are a smoker, how many a day? .....

**We provide a smoking cessation service at Steyning Health Centre and we would recommend you to use this service to aid you in giving up smoking, should you wish to. For a phone call regarding this service please tick this box** ☐

## 12. Alcohol:

Please tick the answer that is correct for you:

**1 unit of alcohol is approx. ½ pint average strength beer/lager or 1 small glass of wine or 1 single measure of sprit**


| 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 times a week ☐ |
| How many units of alcohol do you have on a typical day when you are drinking? | | | | |
| 1 or 2 ☐ | 3 or 4 ☐ | 5 or 6 ☐ | 7 to 9 ☐ | 10 or more ☐ |
| How often do you have 6 or more units on one occasion? | | | | |
| Never ☐ | Monthly or less ☐ | monthly ☐ | weekly ☐ | Daily or almost daily ☐ |

**Alcohol can be detrimental to your health; we can provide help to those whose drinking poses a health risk. Please book an appointment with a GP if you would like to discuss this further**.

## 13. Blood Pressure

**If you are 16 or over, please take your blood pressure using the machine in the first floor waiting room.**

**The machine will print out your reading on a ticket, please write your name and date of birth on this and hand it into reception with this form.**

## 14. Registration for Online Services (Go to section 15 if you do not wish to register for Online Services)

Online services available currently offer you the opportunity for

Online booking of appointments / cancelling and ordering of repeat prescriptions
Online viewing of Test Results and a summary of your health record is soon to be available

If you are over 16 years and applying to register to use the practice's online services for yourself please complete the section below. If you wish to complete a form for children under 12 years or as a Guardian / Carer of another then please ask for a separate form at reception.

1. I agree to use the system in a responsible manner in accordance with all instructions given to me by the practice. If not, access may be withdrawn.

2. I agree that it is my responsibility to keep secure the username and passwords I will be given. If I think these have been shared inappropriately I will reset them using the instructions supplied.

3. I agree that my details may be used to contact me with information about my online account and the online services I use.
   I agree that I may also be contacted about how useful I find the services and whether they could be improved.

4. I agree that online services are provided at the discretion of the practice, and may be withdrawn by the practice at any time.

5. I understand that I cannot use this service as a means of communication with the surgery for other purposes and will not use it for urgent matters.

I wish to register for online services and would like to use the email address and mobile numbers given in section 1 for this purpose

If this email address is shared with others please consider whether you agree that it can be used to send you confidential information about your account / the services used.

Please read the Privacy Policy and Terms & Conditions available on all the Vision Online Service (VOS) web pages. By using VOS, patients automatically indicate their acceptance of the Terms & Conditions.

**To be signed at reception by patient** …… Date ……
**Note: Photo I.D. must be shown**

| | | | | |
|---|---|---|---|---|
| *For practice use only:* | | | *If completed add code #91B* | |
| *Photo ID checked* | | | | |
| *Photo ID* | *Passport* | | *Driving Licence* | |

## 15. Registration Form signature

Please provide a copy of correspondence showing your name and address e.g. utility bill, bank statement etc.

Please sign below to state that the details you have entered on this form are correct and you are happy for this information to be entered on your medical records.

Signed: Date:

**Thank you for completing this form. If you would like a health check with a practice nurse please ask for an appointment at reception.**