MEDWAY MEDICAL GROUP NEW PATIENT QUESTIONNAIRE

REGISTRATIONS ARE DONE MONDAY, TUESDAY AND THURSDAY 11.00AM TO 12.30 AND THURSDAY 16.30 TO 18.00

Name: ____

Please answer the following questions.

1. What is your ethnic background? ____
2. What is your main spoken language? ____
3. Do you require an interpreter? ____
4. Email Address: _____________________ Mobile number:________________________
5. Do you consent for text messaging Yes No
6. Do you consent for email communication Yes No
7. Who is your next of kin? Please give name, relationship and contact number

   ____
8. Do you want to register your details on the Organ donor register: Yes No
9. Do you want to register your details on the blood donor register: Yes No
10. What is your occupation? ____
11. Are you a: Smoker Non-smoker Ex-smoker
12. Would you like advice/support to stop smoking? Yes No
13. What is your height? ____________ What is your weight? ___________
14. Do you consent to having your information shared with other health professionals (Summary Care Record)
    - Express consent for medication, allergies, and adverse reactions only
    - Express consent for medication, allergies, adverse reactions, AND additional information
    - Express dissent (opted out) - Patient does not want a Summary Care Record

15. For the following questions, please circle the answer which best applies

a) How often do you have a drink containing alcohol?

Never   Monthly or less   2-4 times a month   2-3 times a week   4+ times a week

b) How many units of alcohol do you drink on a typical day when you are drinking?

0-2   3-4   5-6   7-9   10+

c) How often have you had 6 or more units if female or 8 or more if male on a single occassion in the last year?

Never   Less than monthly   Monthly   Weekly   Daily or almost daily

16. Would you like Online Access to order your repeat medication and book appointments?

Yes   No

17. Do you have any hearing loss?   Yes   No
18. Do you have any sight impairment   Yes   No
19. Do you have any learning difficulties   Yes   No

POLICY

If you are on any regular medication you may need to make an appointment with the doctor or nurse. PRESCRIPTION REQUESTS TAKE 72 HOURS. WE ARE NOT HELD RESPONSIBLE IF YOU RUN OUT OF MEDICATION.

The surgery has a zero tolerance of abusive behaviour. Unfortunately this behaviour is sadly increasing. We will remove any patient displaying such behaviour from our list.

All 16-24 years olds are required to do a routine Chlamydia test. We will ask you to do this when you return your registration forms.

I understand and agree to the above policy

Signature : ____

Date of Birth : _______________   Date of signature : ________________________

FORMS OF ID SUBMITTED : ____

-FOR OFFICE USE ONLY –

COMPLETED BY :   DATE :