# NEW PATIENT REGISTRATION QUESTIONNAIRE

## PATIENT INFORMATION

| | |
|---|---|
| Name: | Date of birth: |
| Telephone No: | Mobile No: |
| Email: | Ethnicity: |
| First language: | Interpreter required: Yes / No |
| We text patients with appointment reminders and information about our services. Are you happy for us to contact you in this way? | Yes / No |

## EMERGENCY CONTACT DETAILS

| | |
|---|---|
| Name: | Contact No: |
| Relationship to you: | |

## BASIC HEALTH (Please complete smoking and alcohol status for children over 14)

| | |
|---|---|
| Height: | Weight: |
| Do you have any allergies? | |
| Are you a: ☐ Smoker ☐ Ex-smoker ☐ Never smoked | |
| How often do you have a drink containing alcohol?<br>☐ Never ☐ Monthly or less ☐ 2-4 times per month<br>☐ 2-3 times per week ☐ 4+ times per week | |
| How many units of alcohol do you a drink on a typical day when you are drinking?<br>☐ 0-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10+ | |
| 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?<br>☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily | |

**One unit = half pint of regular beer, lager or cider, 1 small glass of wine, or 1 single measure of spirits.*

If you want to stop smoking contact One You Leeds on 0800 1694219 or via www.oneyouleeds.co.uk. If you are concerned about your drinking contact Forward Leeds on 0113 8872477 or via www.forwardleeds.co.uk

## COMMUNICATION NEEDS

| |
|---|
| Do you have any communication, mobility or other needs? ☐ Yes ☐ No<br>If yes please specify: |

## CARER DETAILS – if you tick yes to any carer questions please speak with a member of the reception team when you hand this form in

| | |
|---|---|
| Are you a carer? ☐ Yes ☐ No | Are you cared for? ☐ Yes ☐ No |

# NEW PATIENT REGISTRATION QUESTIONNAIRE

## NOMINATED PHARMACY

| Which pharmacy would you like to nominate to collect your prescriptions from? | |
|---|---|
| Name: | Address: |

## ONLINE SERVICES

You can now book appointments and order repeat prescriptions online.

Would you like to register for online services? ☐ Yes ☐ No

## SUMMARY CARE RECORD

☐ Yes – I would like a Summary Care Record and express consent for medication, allergies and adverse reactions only.
OR
☐ Yes – I would like a Summary Care Record and express consent for medication, allergies and adverse reactions and additional information (eg operations and vaccinations you have had in the past, how you would like to be treated, what support you might need).

☐ No – I do not want a Summary Care Record and express dissent (opt out) for a Summary Care Record (select this option if you DO NOT want any information shared with other healthcare professionals involved in your care).

## SHARING OF HEALTH RECORDS – OUT

Sharing Out – Do you want information entered here to be shareable? You will then be able to choose which other NHS care providers can view the information when you next use their services or when your register for a new service.

Sharing Out ☐ Yes (shareable) ☐ No (not shareable)

## SHARING OF HEALTH RECORDS – IN

Sharing In – Your doctor can currently view information recorded by other NHS care providers that you use. Do you want us to continue to be able to do this?

Sharing In ☐ Yes (viewable) ☐ No (not viewable)

| **Patient Signature:** | **Date:** |
|---|---|

| **STAFF SECTION ONLY** | |
|---|---|
| Name: | Date: |
| Documents seen: | |