**Oak Hall Surgery**

[www.oakhallsurgery.nhs.uk](http://www.oakhallsurgery.nhs.uk)

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**New Patient Questionnaire**

(Revised August 2018)

Welcome to Oak Hall Surgery.

Please book a new patient consultation appointment with a GP. Please complete this New Patient Questionnaire.

Failure to attend or cancel your New Patient Appointment without attending another will mean that you may not be accepted onto our Practice List.

**Personal Details:**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postal Address*(If different from above, please note Holiday Parks may not accept incoming post for individuals)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex Male / Female

Next of Kin Details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Name and how to contact them in an emergency)*

Do you have a Living Will or an Advance Directive in your medical notes? Yes / No

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date form completed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a registered carer? Yes / No

Carers details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Name and how to contact them)*

Are you a registered carer? Yes / No

Do you have a hearing problem? Yes / No

Do you use a wheelchair? Yes / No

Are you registered as having any of the following?

Disabled  Deaf 

Blind  Learning Difficulties 

Approximate Height \_\_\_\_\_\_\_\_\_\_\_

Approximate Weight \_\_\_\_\_\_\_\_\_\_\_

**Ethnic Origin:**

Asian\*  Other Ethnic Group\* 

Bangladeshi  Other European\* 

Black African  Other White Mixed\* 

Black Caribbean  Pakistani 

Chinese  White British 

Indian  White Irish 

Black Mixed\*  \*Please Specify \_\_\_\_\_\_\_\_\_\_\_

**Smoking:**

Do you smoke? Yes / No

If Yes, please state how many per day \_\_\_\_\_\_\_\_\_\_\_

When did you start? \_\_\_\_\_\_\_\_\_\_\_

If you are an ex-smoker, how long did you smoke for? \_\_\_\_

If you smoke and would like help in giving up, support services are available:

**One You Kent / Smokefree Kent – for free products, apps and services:**

**Freephone** 0300 123 1220 or **Text** ‘quit’ to 87023

**Websites**  [kent.gov.uk/smokefree](http://www.smokefreeeasternandcoastalkent.co.uk/) or

https://www.kentcht.nhs.uk/our-services/health-improvement/one-you-smoke-free/

**Local pharmacies** also provide stop smoking programmes.

**Exercise:**

Do you take regular exercise? Yes / No

If Yes, please give further information here \_\_\_\_\_\_\_\_\_\_\_

Would you say your lifestyle is stressful? Yes / No

Are you on any special diet? Yes / No

**Your Name……………………………………………**..

**Females only:**

Date of last Cervical Smear \_\_\_\_\_\_\_\_\_\_\_

Results, if known \_\_\_\_\_\_\_\_\_\_\_

Number of normal deliveries \_\_\_\_\_\_\_\_\_\_\_

Number of caesarean deliveries \_\_\_\_\_\_\_\_\_\_\_

Number of miscarriages \_\_\_\_\_\_\_\_\_\_\_

Have you had a hysterectomy? Yes / No

Are you on any form of contraception? Yes / No

If Yes, please give further information here\_\_\_\_\_\_\_\_\_\_\_

**Allergies:**

Have you ever had an allergic reaction to medication?

Yes / No

If yes, please give further information \_\_\_\_\_\_\_\_\_\_\_

Are you allergic to anything else? \_\_\_\_\_\_\_\_\_\_\_

**Medication:**

Are you currently taking any prescribed medication?

Yes / No (*You will need to see a GP here before obtaining a repeat prescription - continue overleaf if necessary)*

If Yes, please list here \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking any over the counter or homeopathic medications? Yes / No

If Yes, please list here \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your Name……………………………………………………**.

**Medical History:**

Do you have or have you ever been diagnosed with any of the following?

Asthma  Heart Disease/AF/Angina 

Cancer  High Blood Pressure 

Kidney Disease  Epilepsy or ‘Fits’ 

Dementia  Rheumatoid Arthritis 

Depression  Mental Health Problems 

Diabetes  Stroke or TIA 

Thyroid Disease  COPD/Emphysema 

Osteoporosis  Peripheral Arterial Disease 

Liver Disease  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Medical History:**

Has anyone in your family ever been diagnosed with any of the following?

Asthma  Heart Disease/AF/Angina 

Cancer  High Blood Pressure 

Kidney Disease  Epilepsy or ‘Fits’ 

Dementia  Rheumatoid Arthritis 

Depression  Mental Health Problems 

Diabetes  Stroke or TIA 

Thyroid Disease  COPD/Emphysema 

Osteoporosis  Peripheral Arterial Disease 

Liver Disease  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Summary Care Records:**

Have you previously opted out of having a Summary Care Record (SCR)? Yes / No

*Summary Care Record is an electronic record; it will give healthcare staff quicker, easier access to essential information about you, to provide you with safe treatment when you need care in an emergency or when the surgery is closed.* ***If you do not want a summary care record, you******will need to opt out in writing; otherwise it will be assumed that you have no objection.*** *Further information is available from the Practice Manager.*

**Over 16’s Only:**

Please complete this questionnaire, an explanation of alcohol units is on the following page

|  |  |  |
| --- | --- | --- |
| **Questions** | **Scoring system** | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink containing alcohol? | Never | Monthlyor less | 2 - 4 times per month | 2 - 3 times per week | 4+ times per week |  |
| How many units of alcohol do you drink on a typical day when you are drinking? | 1 -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? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |

 **Total:\_\_\_\_\_**

**Your Name……………………………………………………**.

**One unit of alcohol:**

Half a pint of regular beer, larger or cider

1 small glass of wine

1 single measure of spirits

1 small glass of sherry

1 single measure of aperitifs

**Scoring:**

A total of 5+ indicates increasing or higher risk drinking. An overall total score of 5 or above is AUDIT-C positive.

Results over 5 – Please speak to your GP to complete a further AUDIT Questionnaire

**Missed Appointments:**

It is important that you attend any booked appointments during your time at Oak Hall. Multiple missed appointments without cancelling in good time may result in your removal from our practice list.

**Comments and Suggestions:**

Oak Hall Surgery encourages suggestions and comments from patients, you can do this in the surgery or online through our website.

**Your Name……………………………………………………**.

**Extended Opening Hours**

Do you have difficulty in seeing the Doctor during normal opening hours, because you work late, or rely on someone who works late to bring you to the surgery?

If the answer is yes, then please let us know. We may be able to offer you an appointment outside of our normal working hours.

To fit in with work commitments, the best day(s) /time(s)

for appointments with a doctor would be:

Day(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**New Patient Appointment:**

Please bring this booklet and a urine sample to your new patient appointment with the GP. It is important we get to meet you, especially if you are on medication, as your paper records from your previous surgery may experience long delays due to external processing and can take months to arrive.

SCAN QUESTIONNAIRE TO PATIENT RECORD

Revised August 2018

![MCj04315070000[1]]() **Appointment Reminders**

To improve our services to patients, we are offering text message appointment reminders.

**Please inform our receptionist of your current mobile phone number when you are next in touch.**

 **Named GP**

All practices are required to provide their patients with a named GP who has overall responsibility for the care and support their surgery provides to them.

We would like to inform you that Dr Tara Hoshyar will be your ‘named GP.’

As one of our GP Partners, Dr Hoshyar has overall responsibility for the care and support that our surgery provides to you.

**These arrangements do not prevent you making an appointment or seeing any doctor of your choosing within the surgery.**