New Patient Questionnaire: Adults aged over 18 years of age (To be completed with GMS1)

PERSONAL DETAILS			
Name: **Alternative name(s):**		**NHS Number:** **DOB:**	
Email address			
Marital Status (*Please circle)*	Single Married Co-habiting Divorced Separated Widowed Civil Partnership		
Occupation:			
Religion (*Please circle)*	Christian Buddhist Hindu Jewish Muslim Sikh Any other religion, please describe:		
Sexual Orientation (*Please circle)*	Heterosexual / Straight Gay or Lesbian Bisexual Other Prefer not to say		
Do you consider yourself to have a disability? *(Please Circle)*	No Yes: Physical Sensory Learning Disability Mental Health Other:		
Ethnicity (*Please circle)*	**White** British Irish Gypsy or Irish Traveller Any other White background, please describe:	**Mixed/Multiple ethnic groups** White and Black Caribbean White and Black African White and Asian Any other Mixed/Multiple ethnic background, please describe:	
	Asian/Asian British Indian Pakistani Bangladeshi Chinese Any other Asian background, please describe:	**Black/ African/Caribbean/Black British** African Caribbean Any other Black/African/Caribbean background, please describe:	
		Other ethnic group Arab Any other ethnic group, please describe:	
First language:		**Immigration status:**	

COMMUNICATION REQUIREMENTS		
Do you require any of the following: *(Please circle all that apply)*	I need an Interpreter I use lip reading I use textphone / Minicom	I need large print I rely on British Sign Language

NEXT OF KIN / FAMILY DETAILS			
Next of Kin	**Name:**	**Contact Number:**	**Relationship to you:**

Do you have any caring responsibilities for children (under Age 18):		Yes / No *(If yes please fill in section below)*	
Child name: **Child DOB:** **Child Address** *if different to yours:*		**Child name:** **Child DOB:** **Child Address** *if different to yours:*	**Child name:** **Child DOB:** **Child Address** *if different to yours:*

Please list any other adults who reside in your home:		
Full name: **DOB:** **Relation to you:** **GP Details:**	**Full name:** **DOB:** **Relation to you:** **GP Details:**	**Full name:** **DOB:** **Relation to you:** **GP Details:**

MEDICAL HISTORY	
Personal medical history: *(Please circle)* Hearing problems Vision Problem Seizures in Childhood Literacy Problems Allergies Allergies to Medication Hip Problems Heart Conditions Asthma Diabetes Contact with Tuberculosis Infectious Diseases Cancer Mental Health Other (Please specify)	**Any further comments:**
Family medical history: *(Please circle and specify who in further comments)* Hearing problems Vision Problem Seizures in Childhood Literacy Problems Allergies Allergies to Medication Hip Problems Heart Conditions Asthma	**Any further comments:**

Diabetes Contact with Tuberculosis Infectious Diseases Cancer Mental Health Other (Please specify)			
Do you smoke? *(Please circle)*	Yes No	**Do you use drugs?** *(Please circle)*	Yes No
Alcohol Consumption *Please add number of units per week*	____ Units Per Week		

CURRENT MEDICATION *(Please list)*	
Health Condition	**Medication Required**

IMMUNISATION HISTORY	
Immunisation	**Date Given**
BCG	
1st Diptheria/ Tetanus/ Pertussis/ Polio/ Hib 1st Pneumococcal 1st Rotavirus	
2nd Diptheria/Tetanus/Pertussis/Hib 1st Meningitis C 2nd Rotavirus	
3rd Diptheria/Tetanus/Pertussis/Hib 2nd Pnemococcal	
Hib/Meningitis C MMR 1 Pneumococcal booster	
Diptheria/Tetanus/Polio/Pertussis booster	
MMR 2	
HPV (Girls only)	
Diptheria/Tetanus/Polio booster Meningitis C booster	
Other	

To be completed at New Patient Medical

Other service involvement

Service	Practitioner Name	Contact Details

Parenting Capacity

If patient has responsibility for a child consider the impact of their health/ social issues on child eg health conditions, recent bereavement, alcohol/ substance misuse, criminality, relationships, experiences as child, any social care input as child, mental health issues

Family and Environmental Factors

If patient has responsibility for a child consider is anything regarding their living environment likely to impact on child i.e Private/ Council, Secure tenancy/ mortgage, homeless, others in household, is house overcrowded, debt, benefits, financial issues Consider their support network eg: wider family, support networks, community integration,
Discuss fire safety

FGM Routine Questioning

(1) Do you or your partner come from a community where cutting or circumcision is practised? (Please remember you might need to consider that this relates to the patient's parent's country of origin).

(2) Have you been cut? (It may be appropriate to use other terms or phrases)

If you answer YES to questions (1) or (2) please complete FGM risk assessment

Domestic Abuse Routine Enquiry (only question if patient alone)

Prompt questions that may help facilitate routine enquiry for domestic abuse:

1) Do you currently or have you ever felt frightened of someone that you live with?
2) Has your partner ever hit you?
3) Have you ever been emotionally or physically hurt by someone close to you?
4) Have you ever been forced to do anything sexually that you did not want to do?
5) Since you became pregnant have you ever been physically hurt by someone?

(DOH, 2006)

Response to Routine Enquiry

- No experience of domestic abuse
- Declined to answer
- Yes, in the past, not with current partner
- Yes, current experience disclosed
- Unable to ask as partner or other present

Additional Comments:

Signed:	
Date:	