Dr S Marshall (Partner)
Dr K Wight (Partner)
Dr H Bowers (Partner)
Dr D Green (Partner)
Dr K Beaumont
Dr K Mott
Dr R Llewelyn
Dr C Ashley

3 Nithsdale Road
Weston super Mare
BS23 4JP
01934 622 665

WELCOME TO TUDOR LODGE SURGERY

WORKING WITH YOU TO OPTIMISE YOUR HEALTH USING OUR KEY VALUES:

Adaptability
Caring & Courteousness
Clinical Excellence
Efficiency
Sustainability
Service Focus

Dear Patient

Thank you for choosing Tudor Lodge. Our focus is you, and to help us offer you what you need we need a little help.

We know form filling isn't your favorite pastime! But the more information you can give us about you, your family, and your lifestyle, the better equipped we are to help you stay healthy.

Please complete the attached questionnaire, don't worry if you can't answer all of the questions or if there are some questions you prefer not to answer. If you need more than the space provided, just attach additional information on a separate sheet.

If you have difficulty filling in forms, we are here to help just ask one of our reception staff to help you.

If there is anything you are not sure of or you have any questions please contact us.

Don't forget – We are online at www.tudorlodgesurgery.nhs.uk

48 hours after registering as a patient you can register online. The benefits of using our online service are :

- **AskMyGP** – Send your request for appointments or queries to a clinician
- **Patient Access** mobile app – Free on Android and iOS
- Booking appointments –Nurses& HCA's
- Ordering repeat prescriptions
- Secure messages
- Medical record and updating your details.
- Viewing our most frequently asked questions

TUDOR LODGE SURGERY
New Patient Questionnaire

For reception use:
Given patient the Practice Leaflet ☐
Repeat script attached ☐
Completed in full ☐

Today's date:…………………….

PATIENT INFORMATION

Title: Miss ☐ Ms ☐Mrs ☐ Master ☐Mr☐Dr☐ Other:

First Name	**Middle (1)**	**Middle (2)**	**Last Name**

Is this your legal name?Yes ☐ No ☐

If No what is your legal name?

Marital Status: Single ☐Married ☐ Divorced ☐ Separated ☐ Widow/Widower ☐
Common Law/Co-habiting☐

CONTACT DETAILS:

Home Address	**Telephone/e-mail**
	Home:
	Work:
	Mob:
	E-mail: We may e-mail you from time to time with updates from the surgery.

Would you be interested in online access? Yes ☐ No ☐

Appointments are requested through AskMyGP, see our website for more information or speak to a receptionist. You will need to come to the surgery to collect your application for on line access form and show us a form of Identification such as Passport, Birth Certificate, Driving Licence, bank statement. It is well worth doing this, once you have on line access you can see various elements of your medical record including test results and immunisations.

NEXT OF KIN DETAILS

NAME	RELATIONSHIP TO PATIENT	Telephone/e-mail

Is there anyone you would like us to contact locally in case of emergency? Yes ☐ No ☐

Name:

Tel. No.

Do you live in a Care Home? Yes ☐No ☐

Do you live in a Residential Home? Yes ☐No ☐

Do you live in a Nursing Home? Yes ☐No ☐

Do you live in sheltered housing/warden supported? Yes ☐No ☐

Are you housebound? Yes ☐No ☐

If **Yes** do you ever leave the house for e.g. to go shopping/restaurant/hairdressers?Yes ☐No ☐

If Yes, how often do you get out?

Daily☐

Weekly ☐

Monthly ☐

Virtually never ☐

CHILDREN

Do you have children age 16 or under? Yes ☐No ☐

Please list all of your children aged under 16 even if they are not registered at Tudor Lodge Surgery

FIRST NAME	LAST NAME	DATE OF BIRTH	Male/ Female	NAME OF COLLEGE/ SCHOOL/NURSERY - Please include tel. no. if possible	Please state for each child whether you are Parent, Carer, Guardian or other relationship

Are any of your children acting as a carer for you?Yes ☐ No ☐

Do you currently have any support from Social Services?Yes ☐ No ☐

If yes, what support are you currently receiving?

Parental Responsibility:

For the benefit of both yourself and your child/children it is important that we are aware who has parental responsibility for your child/children, both for their health and welfare as well as data protection. A mother automatically has parental responsibility for her child from birth.

A father usually has parental responsibility if he is:

- married to the child's mother
- listed on the birth certificate (after a certain date, depending on which part of the UK the child was born in – 05/05/2006 Scotland and 15/04/2002 North Ireland)

Unmarried parents

An unmarried father can only get parental responsibility for his child in 1 of 3 ways:

- jointly registering the birth of the child with the mother (from 1 December 2003)
- getting a parental responsibility agreement with the mother
- getting a parental responsibility order from a court

We will need proof of parental responsibility if you want to obtain any information about your child.

Confidentiality

There may be times when we share information about your child/children with other health and social care services if we believe it is in their best interest. Please ask if you would like further information.

VETERANS

Are you a veteran? Yes ☐ No ☐

This applies to anyone who has served in the military immaterial of how long you served i.e. if you left after 1 day you are still considered a veteran.

The reason we ask this question is because you may be entitled to additional support or be prioritised when referred to secondary services/hospital.

CARER INFORMATION

Are you Carer? Yes ☐ No ☐

You are considered to be a Carer if you look after someone who would struggle to cope without you. Carers are entitled to extra support for e.g. Health Check, flu immunisation

YOUR LIFESTYLE

Are you a Smoker ☐ **Ex-Smoker** ☐ **Never smoked** ☐

If **YES** circle type - Cigarettes/cigar/pipe/roll your own. Quantity per day ☐

If you have given up smoking, well done! Please tell us when you quit and how many a day you used to smoke in the past.

Gave up …………….(date or year), amount smoked in the past……………. Per day

For the sake of your health and those around you we strongly advise that you consider giving up. A list of options for stopping is attached.

The surgery offers a smoking service, do you want us to contact you to provide smoking cessation advice?Yes ☐ No ☐

MEDICAL HISTORY

Have YOU or any of your <u>immediate</u> family suffered from any of the following?If family member please state relationship e.g. brother, sister etc.

	SELF	**FAMILY**	**RELATIONSHIP**
Asthma	☐	☐	
Bowel Cancer	☐	☐	
Breast Cancer	☐	☐	
Diabetes (Type) Is your glucose level well controlled Yes ☐No ☐	☐	☐	
Epilepsy	☐	☐	
Heart problems (please specify e.g. Angina, Atrial Fibrillation etc.)	☐	☐	
High Blood pressure	☐	☐	
High Cholesterol	☐	☐	
Stroke	☐	☐	

Do you have any allergies? (NB: include allergies to medication): Yes ☐ No ☐

If YES please list:

Do you have a learning disability?

Yes ☐ No ☐

Please give details so we can best help you

………

Have you had any serious illnesses or operations?

ILLNESS/OPERATION	DATE

CURRENT MEDICATION

Are you on regular medications? If YES please list and either bring your last repeat slip or your medication with you to your first appointment at the Surgery.

GENERAL HEALTH

CHLAMYDIA SCREENING -If you are over the age of 25 would you like to be sent a chlamydia screening kit?Yes ☐ No ☐

We can post the test to you and drop it back to the surgery when you are done.

If you are aged between 16 and 24 you can order a test on www.freetest.me

You are at greater risk if you are under 25 and had more than one partner in the last year.

HEALTH CHECK: 40 – 74 years old? Have you had a health check in the last 5 years? Yes ☐ No ☐

Would you like us to contact you to book one?Yes ☐ No ☐

WOMEN ONLY:

Do you perform self-breast examination? Yes ☐ No ☐

Do you want more info on how to do it? Yes ☐

Do you have regular smear tests? Yes ☐ No ☐

Do you use contraception? Yes ☐ No ☐

If YES. What type ______________________________

Do you find this form of contraception satisfactory? (we offer full range of options)Yes ☐ No ☐

MEN ONLY:

Do you check your testes regularly (for lumps) Yes☐ No ☐

Do you want more info on how to do it? Yes ☐

BLOOD PRESSURE:

When you return this questionnaire to the Surgery we have a blood pressure machine in the upstairs waiting room area which we would like you to use. Your blood pressure result will be printed out. Please attach this to your questionnaire and hand in at reception.

Please feel free to visit the surgery at any time to use our Blood Pressure Machine but if you leave a reading for us, ensure your name and date of birth is written on the ticket so we can record it in your records.

ETHNICITY

Is English your first language? Yes ☐ No ☐

Do you need a translator? Yes ☐ No ☐ If so which language ______________

How would you describe yourself?

Choose ONE section from A to E, and then tick the appropriate box

A ☐ Asian or Asian British

☐ Bangladeshi

☐ Indian

☐ Pakistani

☐ Any other Asian background, please write in box ....

B ☐Black or Black British

☐ African

☐ Caribbean

☐ Any other Black background, please write in box ....

C ☐ Chinese or other ethnic group

☐ Chinese

☐Any other, please write in box ....

D ☐Mixed Heritage

☐White and Asian

☐White and Black African

☐White and Black Caribbean

☐Any other Mixed background, please write in box ....

E ☐White

☐ British

☐ English

☐ Irish

☐ Scottish

☐ Welsh

☐ Any other White background, please write in box ....

Physical Activity Questionnaire

You may be more active than you think! You don't need to take structured exercise to be active, just doing housework, walking the dog, doing some gardening all add up. Please complete the following

Your Name .... and date of birth ....

Please tick each section	Please tick as appropriate ✓
Physical Activity involved at work	
Not in employment	
Spend most of my time at work sitting	
Spend most of my time at work standing or walking	
My work involves definite physical effort	
My work involves vigorous physical activity	
Physical Exercise	
Hours of physical exercise in the last week – none	
Hours of physical exercise in the last week – some but less than 1 hour	
Hours of physical exercise in the last week – more than 1 hour but less than 3 hours	
Hours of physical exercise in the last week – 3 hours or more	
Cycling	
Hours spent cycling in the last week – none	
Hours spent cycling in the last week – some but less than 1 hour	
Hours spent cycling in the last week – more than 1 hour but less than 3 hours	
Hours spent cycling in the last week – 3 hours or more	
Walking	
Hours spent walking in the last week – none	
Hours spent walking in the last week – some but less than 1 hour	
Hours spent walking in the last week – more than 1 hour but less than 3 hours	
Hours spent walking in the last week – 3 hours or more	
Housework and Childcare	
Hours spent on housework or childcare in the last week – none	
Hours spent on housework or childcare in the last week – some but less than 1 hour	
Hours spent on housework or childcare in the last week – more than 1 hour but less than 3 hours	
Hours spent on housework or childcare in the last week – 3 hours or more	
Gardening/DIY	
Hours spent on gardening/DIY in the last week – none	
Hours spent on gardening/DIY in the last week – some but less than 1 hour	
Hours spent on gardening/DIY in the last week – more than 1 hour but less than 3 hours	
Hours spent on gardening/DIY in the last week – more than 3 hours	
Walking Pace	
I would describe my normal walking pace as – slow	

I would describe my normal walking pace as – steady	
I would describe my normal walking pace as – brisk	
I would describe my normal walking pace as – fast	

Surgery use only – add as GP Physical Activity Questionnaire using Emis Template

Alcohol Screening – Audit C

Your alcohol consumption is really important for your GP to know. Please complete this form to help us understand how much you drink.

Your Name ………………………………………………………… and date of birth ……………………………

Please tick each section	Please tick as appropriate ✓
How often do you have a drink containing alcohol?	
Never	
Monthly or 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 drinks	
2-3 drinks	
5-6 drinks	
7-9 drinks	
10+ drinks	
How often do you have 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	
Would you like to see someone at the surgery to talk about cutting down your drinking?	Yes / No (circle as appropriate)

Surgery use only – add as Audit C using Emis Template