

***Main Surgery***:

Istead Rise Surgery,

Worcester Close,

Istead Rise,

GRAVESEND,

Kent DA13 9LB

**Telephone:**

**01474 247003**

Dr David J Payne

Dr Devinder S Mahil

Dr Tariq S Hussain

Dr Rupal Patel

Dr Reena Jacob

Dr Hajane Jeyabalasingam

Mrs Zara J Williamson

Mr Keith D Fuller

 VAT registration No: 879 1358 76

**NEW PATIENT QUESTIONNAIRE**

Welcome to Downs Way Medical Practice. As it takes a few weeks before your records arrive from your former surgery, please complete this questionnaire to enable us to provide you with appropriate medical care.

|  |  |
| --- | --- |
| Title | Mr / Mrs / Miss / Ms |
| Name |  |
| Address |  |
|  |  |
| Date of birth: |  |
| Tel: | Home  | Work |
|  | Mobile |
| E Mail address |  |
| Ethnic Origin |  |
| Main Spoken Language |  |
| Is English your second language? | Yes No |
| Occupation |  |
| Allergy (medicines) |  |
| Allergy (others) |  |
| Height: |  | Weight: |
| Smoker | Y / N No: per day |
| Ex-smoker  | Date stopped: |
| Current Medication(s) & dose: |  |
|  |  |
|  |  |
| (Women) Contraceptive used |  |
| Date of last smear: |  |
| **Family History**  | **Relationship to you** | **Age at diagnosis** |
| Heart attack |  |  |
| Angina |  |  |
| Stroke |  |  |
| Cancer |  |  |
| Diabetes |  |  |

**Please turn over and complete side 2.**

If you are 16 or over, please complete this short questionnaire:

|  |  |
| --- | --- |
| Audit C QuestionnaireFor the following questions please tick the answer which best applies. | 1 drink = 1/2 pint of beer or 1 glass of wine or 1 single spirits |
| 1. How often did you have a drink containing alcohol in the past year?
 | **Never****[ ]** 0 | **Monthly or Less****[ ]** 1 | **Two to four times a month** **[ ]** 2 | **Two to three times per week** **[ ]** 3 | **Four or more times a week** **[ ]** 4 |
| 1. How many drinks did you have on a typical day when you were drinking in the past year?
 | 1 or 2 **[ ]** 0 | 3 or 4 **[ ]** 1 | 5 or 6**[ ]** 2 | 7 or 9 **[ ]** 3 | 10 + **[ ]** 4  |
| 1. How often did you have six or more drinks on one occasion in the past year?
 | **Never** **[ ]** 0 | **Monthly or Less****[ ]** 1 | **Monthly** **[ ]** 2 | **Weekly** **[ ]** 3 | **Daily or almost Daily** **[ ]** 4 |

Signed : Date:

Staff use only: Revised Aug 2024

Patient Name……………………………….. Date of Birth……………………………

Address……………………………………………………………………………………

…………………………………………………………………………………………………

…………………………………………………………………………………………………

At Downs Way Medical Practice we want to make sure that we give you information in a way that is clear to you.

We are writing to you to ask if you find it difficult to read or understand information that we may send to you or need us to communicate with you in a particular way at the surgery. Please put a tick in the boxes that describe your preferred means of communicating.

When we write to you or contact you, do you need us to communicate in a particular way?

 Yes

 No

If your answer is yes, please tell us which way you would prefer us to communicate with you. You may tick more than one box but please make your preference clear.

 By phone

 I prefer to use the phone and I use a hearing aid

 I prefer to use the phone and do not use a hearing aid

 By email

 I use a screen reader

 I do not use a screen reader

 By text message

 I use a text to speak app

 I do not use a text to speak app

 With Easy Read pictures and words

 By letter using large type

 When you come to the surgery do you need a British Sign Language interpreter?

If you need anything that is not on the list above, please tell our receptionist when you come in for your next appointment and we will do our best to meet your needs.

# Application for Online Access

To apply for this service please complete this form and return it to the Surgery in person. You will need to bring photo ID\* and proof of address^. You will need an individual e mail address to apply for the service. Registration details will be e mailed to you. **Please note they expire one month after issue, so if you haven’t activated it by then, you will need to reapply.** If you require online access to Detailed Medical Records, ask for the additional form.

*\*ID needs to show a current photo and signature, eg Current Passport or Driving Licence*

*^ Photocopies will be taken and kept on file*

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name |
| AddressPostcode  |
| Personal Email address (not shared):  |
| Telephone number | Personal Mobile number |

## I wish to have access to the following online services (please tick all that apply):

|  |  |
| --- | --- |
| 1. Booking appointments
 | 🞏 |
| 1. Requesting repeat prescriptions
 | 🞏 |
| 1. Accessing my Online Summary (Medications & Allergies) **(#93440)**
 | 🞏 |

**I wish to use Online Services. Please read each statement carefully and tick before signing.**

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the practice
 | 🞏 |
| 1. I will be responsible for the security of the information that I see or download
 | 🞏 |
| 1. If I choose to share my information with anyone else, this is at my own risk
 | 🞏 |
| 1. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement
 | 🞏 |
| 1. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible
 | 🞏 |
| 1. I agree to be added to the Patient Group to receive information and surveys about the Practice
 | 🞏 |

**I understand and agree with all the above statements:**

|  |  |
| --- | --- |
| Signature | Date |

### For practice use only

|  |  |
| --- | --- |
| Patient NHS number | Vision ID number |
| Identity verified by(initials) | Date | Method Vouching 🞏Vouching with information in record 🞏 **Photo ID and proof of residence 🞏** |
| Authorised by   | Date |

**Military Service Questionnaire**

Name……………………………………………………………… Date of Birth…………………………….

1. Have you ever served in the UK Armed Forces? YES □ NO □

If YES, please provide details under Question 2:

1. Are you currently serving in the UK Armed Forces (this includes reservists or part time service, eg Territorial Army)? YES □ NO □

If YES, please provide details:

Service (eg Royal Navy, Army, Royal Air Force) …………………………………………..

Regular □ Reserve □ Rank/rate……………………………………………

Service Number (if you can remember if – doesn’t matter if you can’t)

……………………………………………………

Approx dates of service – from………………………….. to…………………………………………

1. Are you a member of a current or former serviceman or woman’s immediate family/household? YES □ NO □

If YES – please provide details of the current/former serviceman/woman and their relationship to you.

Their name……………………………………. Their date of birth…………………………………..

Relationship to you…………………………………………………………

Service (eg Royal Navy, Army, Royal Air Force) …………………………………………..

Regular □ Reserve □

Office use only:

Coded onto emis using guideline template □ Initials……… date…………………..