

# Malpas Surgery

Old Hall Street, Malpas, Cheshire SY14 8PS  
Tel: 01948 860205 Practice Code: N81038

**Partners:** Dr Louise M C Davies  
Dr Richard W S Henney  
Dr Mark R Edney  
Dr Christine L Snowden  
Mrs Lynn Suckley MBA

## NEW PATIENT QUESTIONNAIRE FOR PATIENTS AGED 16 YEARS AND OVER

Now that you have registered with our practice your medical records will be forwarded to us from your previous doctor as soon as possible.

However as this process can take quite a time, please complete this questionnaire as fully as possible. The information that you give us will assist us to give you the best possible care.


Personal Details		
Title:	Surname:	Forenames:
Address:		
Postcode:		
Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/> Separate <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Marital state unknown <input type="checkbox"/>		
Date of Birth:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Prefer not to say <input type="checkbox"/>	
Home Tel No:	Mobile Tel No:	
Email Address:		
Occupation:		
Work Tel No:		
Next of Kin:	Next of kin Address:	
Relationship:		
Contact Number:		

Carer Details	
Are you a Carer for another person?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, Name of the person you care for:	

Ethnicity & Language	
White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Chinese <input type="checkbox"/> Other .....	
What is your first language?	English Yes <input type="checkbox"/> No <input type="checkbox"/> Other .....

Disability	
Do you consider yourself to have a disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, details of impairment	Learning disability/difficulty <input type="checkbox"/> Mental Health Condition <input type="checkbox"/> Other .....

Consent	
We use email to send information eg. Newsletters, Patient Participation Group information or job vacancies. This <b>DOES NOT</b> include any personal correspondence or clinical information and is not used for communicating with the doctor.	
Please tick if you are happy to receive general information by email.	<b>Consent to receive emails</b> [ <input type="checkbox"/> ]
	<b>Declined consent to receive emails</b> [ <input type="checkbox"/> ]
We use text messaging for:	
<ul style="list-style-type: none"> <li>• Appointment reminders</li> <li>• To ask you to arrange follow up blood tests</li> </ul>	
To advise you of blood test results	
<ul style="list-style-type: none"> <li>• To send information eg; fit notes, exercise sheets and links to medical information</li> <li>• Short messages from your Doctor or Nurse</li> </ul>	
Please tick if you consent to receive text messages for the above.	<b>Consent to receive text messages</b> [ <input type="checkbox"/> ]
	<b>Declined consent to receive text messages</b> [ <input type="checkbox"/> ]

Alcohol	
Alcohol use can affect your health.	
You can use the guide. Or visit <a href="https://www.drinkaware.co.uk/understand-your-drinking/unit-calculator">https://www.drinkaware.co.uk/understand-your-drinking/unit-calculator</a>	
How Often do you have a drink containing alcohol?	[ <input type="checkbox"/> ] Never [ <input type="checkbox"/> ] Monthly or less [ <input type="checkbox"/> ] 2-4 times per month [ <input type="checkbox"/> ] 2-3 times a week [ <input type="checkbox"/> ] 4 or more times a week
How many standard drinks containing alcohol do you drink on a typical day?	[ <input type="checkbox"/> ] 1 or 2 [ <input type="checkbox"/> ] 3 or 4 [ <input type="checkbox"/> ] 5 or 6 [ <input type="checkbox"/> ] 7 or 9 [ <input type="checkbox"/> ] 10 or more
How often do you have 6 or more units on one occasion?	[ <input type="checkbox"/> ] Never [ <input type="checkbox"/> ] Less than monthly [ <input type="checkbox"/> ] Monthly [ <input type="checkbox"/> ] Weekly [ <input type="checkbox"/> ] Daily or almost daily

Lifestyle Information – Important information for your ongoing healthcare			
Smoking			
Do you smoke?	[ <input type="checkbox"/> ] Yes [ <input type="checkbox"/> ] No	If yes, how many per day?	
How many years have you smoked for?		Are you an ex-smoker?	[ <input type="checkbox"/> ] Yes [ <input type="checkbox"/> ] No
Would you like support and/or information to help you give up smoking?			[ <input type="checkbox"/> ] Yes [ <input type="checkbox"/> ] No
Other Information			
What is your height?		What is your weight?	

Females Only			
Are you pregnant?	[ <input type="checkbox"/> ] Yes [ <input type="checkbox"/> ] No	If yes, when is your baby due?	
Contraception – Do you use any of the following methods?			
Coil [ <input type="checkbox"/> ] When was it fitted?		Implant [ <input type="checkbox"/> ] When was it fitted?	
Contraception Injection [ <input type="checkbox"/> ] When is this next due?			
Cervical Screening			
Date of last cervical smear?		Have you had a hysterectomy?	[ <input type="checkbox"/> ] Yes [ <input type="checkbox"/> ] No

<b>Medical History</b> (please tick the medical problems that you have)			
	<b>Tick</b>	<b>Details</b>	<b>Date (if known)</b>
Asthma			
Chronic Obstructive Pulmonary Disease (COPD)			
Diabetes			
Heart attack/disease			
Stroke			
Chronic Kidney Disease			
Raised blood pressure			
Cholesterol level over 5.5			
Cancer			
Epilepsy			
Osteoporosis			
Underactive/Overactive Thyroid			
Other serious illness			

<b>Allergies</b>	
Any known allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, allergic to:</i>
Details of the reaction	

<b>Family Medical History</b> <i>Has any of your family had any serious health problems?</i>		
	<b>Tick</b>	<b>Details</b>
Asthma		
Cancer		
Diabetes		
Heart Attack or angina		
Stroke		
Other inherited diseases		

<b>Access to your Records for Appointments and Repeat Prescriptions for patients age 18years &amp; over:</b>
<p>Patients can have access to their records for the following:</p> <ul style="list-style-type: none"> <li>• Make or cancel an appointment with your Doctor</li> <li>• Change your address</li> <li>• Order your Repeat Prescription</li> </ul> <p>We advise that you do this by downloading the NHS App to your mobile device.</p> <p>You can also use Patient Access – please see our website for further information.</p> <p>If you would like us to send you joining details for Patient Access please tick this box <input type="checkbox"/></p>
<b>Access to you Full Medical Record for patients age 18years &amp; over:</b>
<p>Once we have received your medical record from your previous surgery you are able to obtain access to your full medical record. An Application Form to apply for this is available from the Receptionists.</p> <p>Please note that it can take some weeks for your complete record to be received by the practice.</p>

<b>Repeat Medication</b>			
Are you on any repeat medications?		[ ] Yes [ ] No	
Please give us as much information as possible about the medication you are taking. Please tick if you are enclosing a repeat prescription form from your previous surgery.		[ ] Yes [ ] No <i>If yes, please hand this to reception</i> <i>If no, please list below your current medication</i>	
Complete the following with details of ALL medication you are taking <b>Please include any over the counter medication that you take</b> There is no need to list the items on your repeat prescription if you are giving us your repeat form.			
<b>Name of Medication</b>	<b>Dosage</b>	<b>How often do you take it</b>	<b>Reason for using this medication</b>

All prescriptions are now sent electronically to our dispensary or a pharmacy of your choice.

If you live more than one mile (1.6km) from a chemist, we will dispense your medication from our dispensary. If you live within 1 mile of a chemist we cannot dispense your medication. You can nominate a pharmacy of your choice to collect your prescriptions. Please choose one of the local pharmacies listed below or complete with details of your choice and we will register them on your record.

**Local Pharmacies:**

<b>Name &amp; Town</b>	<b>Postcode</b>	<b>Please Tick</b>
Well Pharmacy, Malpas	SY14 8NU	
Rowlands Pharmacy, Whitchurch	SY13 1AX	
Green End Pharmacy, Whitchurch	SY13 1AD	
Boots Pharmacy, Whitchurch	SY13 1DW	
The Pharmacy, Farndon	CH3 6PT	
Well Pharmacy, Tattenhall	CH3 9PX	
Rowlands Pharmacy, Tarporley	CW6 0AB	
Other (please provide name and town & postcode)		

Your prescription will be ready for collection from our dispensary **AFTER 5 working days** from your order being received. Please ensure you have an adequate supply of your medication particularly in the run up to bank holidays when the surgery is closed.

**Prescription Charges**

A prescription charge will be made for each item purchased unless you fall into one of the exemption categories. We request sight of proof of exemption each time you collect your prescription if you do not pay. Prepayment certificates are available for patients on 2 or more regular medication in each month: please ask for an application form. We accept payment by cash, credit/debit card or cheque.

**ALL PATIENTS:**

**Shared Care Record (SCR)**

Malpas Surgery takes part in the data extractions and we want you to have information about this so that you can make a fully informed choice of allowing your data to be shared outside the practice.

**You have a choice -**

Of what information you would like to share and with whom. Authorised healthcare staff (ie. Consultants in any NHS England hospital) can only view your SCR with your permission. The information shared will solely be used for the benefit of your care. If you do not wish to do so you can “opt out” by ticking the appropriate box. Please be reassured that your access to health care and the care you receive will not be affected by your decision.

Your options are outlined below; please indicate your choice on the form overleaf.

- a) **Express consent for Summary Care Record; medication, allergies and adverse reactions only.**  
You wish to share information about medication, allergies and adverse reactions only.
  
- b) **Express consent for Enhanced Summary Care Record; medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies and adverse reactions and further medical information that includes: Your significant illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.
  
- c) **Express dissent for Summary Care Record (opt out).** Select this option, if you **DO NOT** want any information shared with other healthcare professionals involved in your care.

Please note that it is not compulsory for you to complete this consent form. If you choose not to complete this form, an Enhanced Summary Care Record containing information about your medication, allergies, adverse reactions and additional further medical information will be created for you as described in point b) above.

You are free to change your decision at any time by informing us at the surgery.

**Summary Care Record Patient Consent Form**

Having read the above information regarding your choices, please choose **one** of the options below by ticking one box:

**Yes – I would like a Summary Care Record**

Express consent for Shared Care Record; medication, allergies and adverse reactions only.

**or**

Express consent for Enhanced Care Record; medication, allergies & reactions, additional information.

**No – I would not like a Summary Care Record**

Express dissent for Summary Care Record (opt out).

Signature: .....

Date: .....

**Please bring in a form of photo ID when dropping off your registration forms into the surgery**  
i.e. photo driving license or passport.

**Thank you for taking the time to complete this questionnaire.**

Office Use Only			
Proof of identity	Passport <input type="checkbox"/>	Photo Driving License <input type="checkbox"/>	Other:
Proof of address	Utility Bill <input type="checkbox"/>	Bank Statement <input type="checkbox"/>	Other:
Initials of Staff member		Date	