Medical & Alcohol Questionnaire – to be completed with the Patient Registration GMS1 form for Scott Road Medical Centre, Selby
PLEASE COMPLETE THIS FORM IN FULL USING BLOCK CAPITALS

In order to register you we will need sight of two forms of ID: 1 form of photo ID (eg. passport, driving licence) and 1 form of ID showing proof of occupancy of the home address you detail below (eg. utility bill, council tax statement)

Your Named GP at the Practice Will Be **Dr**
(Admin please update code **Xab9D** and **XacWQ** and include GP Name)

Have you ever been registered at this practice before? Yes ☐ No ☐

Please provide a copy of your repeat medication slip from your previous GP

For some patients we are able to send prescriptions by electronic transfer to a pharmacy. If you wish to use this service please advise us which pharmacy you wish to nominate	Pharmacy Name & Location

General Information	
Full Name	
Date of Birth	
My height	
My weight	

Contact Details	
Mobile Number	
Home Number	

Please tick the box if you only wish to your mobile number to be used for telephone calls and object to receiving SMS messages from the practice ☐

Email	
Email address	

We occasionally use your email address to communicate with you about your direct medical care.

We can use email to send you other useful information unrelated to your direct medical care - for example surgery newsletters, surgery information, staff changes, and minutes of patient group meetings – *but only with your explicit consent.*

If you would like to receive this sort of information from us, then please do let us know by ticking the box below.

You can withdraw your consent to receive these types of emails (whilst still allowing the surgery to email you for direct medical care purposes) at any time – just let the surgery know.

☐ **Please tick here if you consent to Scott Road Medical Centre contacting you by email with Non-medical information (such as surgery newsletters)**

We never pass your email onto any third parties (unless you have given us your explicit consent to do so)

Do you suffer from allergies or sensitivities?
If Yes, please provide details

Specific Needs: Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:	
Are you a military veteran ?	
Please state any Sensory Impairment you have (i.e. Speech, Hearing, Sight):	
Are you an 'Assistance Dog' User?	
Please state any Physical disabilities you have:	
Please state any Mental disabilities you have:	
Please state any requirements you have to be able to access the Practice premises	
Please state any phobias you have:	

If you have a Carer, please state their name / address / phone number and sign here if you wish us to disclose information about your health to your Carer.	Carer Contact Details:
If you are a Carer, please state your name/address/phone number of the person who you care for:	Person Cared for Contact Details:

Employment status (over 16's only) - Please tick the box that applies to you			
I am employed full time	☐	I am unemployed	☐
I am employed part time	☐	I am retired	☐
I am self employed	☐	I am medically retired	☐
I am a student	☐		

First language - Please tick only 1 box	
English	☐
Polish	☐
Other (please specify)	

Ethnicity – Please tick only 1 box			
White	British	☐	XaJQv
	Irish	☐	XaJQw
	Any other white background	☐	XaJQx
Mixed	White & Black Caribbean	☐	XaJQy
	White & Black African	☐	XaJQz
	White & Asian	☐	XaJR0
	Any other mixed background	☐	XaJR1
Asian or British Asian	Indian	☐	XaJR2
	Pakistani	☐	XaJR3
	Bangladeshi	☐	XaJR4
	Any other Asian background	☐	XaJR5
Black or Black British	Caribbean	☐	XaJR6
	African	☐	XaJR5
	Any other background	☐	XaJR8
Any Other Ethnic Background	Chinese	☐	XaJR9
	Any other (please describe)		XaJRA
Do not wish to state ethnicity		☐	XE0oc

Family History - Please tick ANY box that applies to you	
A member of my family suffers from Diabetes Family member who suffers from this condition e.g. Father, Mother, Brother, Sister	☐
A member of my family suffers from Hypertension Family member who suffers from this condition e.g. Father, Mother, Brother, Sister	☐
A member of my family suffers from Heart Disease and this started BEFORE they were 60 years of age Family member who suffers from this condition e.g. Father, Mother, Brother, Sister	☐
A member of my family suffers from Asthma Family member who suffers from this condition e.g. Father, Mother, Brother, Sister	☐

Smoking status – Please tick only 1 box		
I am a smoker	☐	If you are a smoker and would like help in trying to stop please contact reception 01904 724400 or North Yorkshire Stop Smoking Service on 0300 303 1603
I am an ex-smoker	☐	
I have never smoked	☐	
I am not willing to disclose	☐	

Alcohol screening (over 16's only)
1 unit = ½ pint of beer or 1 single shot of spirits. 1 small glass of wine = 1.5 units (136)

Number of units you drink per week =

We are required by the Clinical Commissioning Group (CCG) to ask all new patients aged 16 and over how much and how often do you drink alcohol?

Please help us help you by completing this quick survey. Thank you.

For each question tick the answer that applies to you.

If your answer to the first question is ‘Never’ there is no need to complete this questionnaire.

Part 1

Score	0	1	2	3	4	
How often do you have a drink that contains alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	**Your score**
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1 – 2	3 – 4	5 – 6	7 – 8	10+	**Your score**
How often you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	**Your score**
				Your score for Part 1		

Part 2a – Please only complete Part 2a & Part 2b if you scored 5 or more in Part 1

Score	0	1	2	3	4	
How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	**Your score**
How often in the last year you have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	**Your score**
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	**Your score**
How often in the last year have you had a feeling of guilt or regret after drinking	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	**Your score**
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	**Your score**
				Your score for Part 2a		

Part 2b

Score	0		2		4	
Have you or someone else been injured as a result of your drinking?	No		Yes but not in the last year		Yes, during the last year	**Your score**
Has a relative/friend/ health worker been concerned	No		Yes but not in the last		Yes, during the	**Your score**

about your drinking and advised you to cut down?			year		last year	
					Your score for Part 2b	

Your score from Part 1	
Your score from Part 2a & b	
Your total score	

Patient Participation Group	
The Practice is committed to improving the services we provide to our patients. To do this it is vital that we hear from people about their experiences, views and ideas for improving services. By expressing your interest, you will be helping us to plan ways of involving patients that suit you. It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice.	
Yes I am interested in becoming involved in the Patient Participation Group and would like to be contacted by a representative from the group (please tick)	Yes
You can opt out at any time, please contact us here at the surgery. This will not affect any other care we provide for you.	

Summary Care Record

We will upload certain elements of your medical record onto the NHS spine to allow other providers (NHS hospitals, 'out of hours' providers) site of your medical record.

The only elements to be uploaded are

1. Medication issued in the last 12 months
2. Any allergies you have
3. Any adverse reactions you may have had

Please tick only one box below, if you fail to tick a box we will assume implied consent and share these elements of your record.

I give express consent for medication, allergies & adverse reactions ☐

I dissent (opt out) & do not want to share my record ☐

I confirm that all details on this form are accurate.

Signature of Patient ☐ ………………………………………… Date:……………………

Or

Signature on behalf of Patient: ☐ ………………… ……………………. Date: …………………….