Photographic ID		Proof of Home Address		Accepted By		Date		Emis No	

Receptionist to initial

NEW PATIENT QUESTIONNAIRE

Name		Date	
Address		Date of Birth	
		Occupation	
Tel No	Home:	Marital Status	
	Work:		
	Mobile:	Email	
If you would like your prescription request to be proceeded through the electronic prescription system please inform us of your nominated pharmacy.		Pharmacy Name	

What is your first language? _____

Ethnic Origin (Please tick one box)

White	1. British		2. Irish		3. Other White			
Mixed	4. White and Black Caribbean		5. White and Black African		6. White and Asian		7. Other mixed	
Asian or Asian British	8. Indian		9. Pakistani		10. Bangladeshi		11. Other Asian	
Black or Black British	12. Caribbean		13. African		14. Other Black			
Chinese or other	15. Chinese		16. Other ethnic group		17. Don't Know/not sure		18. Would rather not state	

Do you give permission for messages to be left on an answer-phone? YES/NO

If not is there someone else we can leave a message with? YES/NO Who:_____

Have you ever smoked **tobacco**? Yes / No If you answered Yes and you still smoke, please indicate how many of what per day. If an ex-smoker, please give the same details and the date you stopped smoking.

How many cigarettes do/did you smoke per day _____ When did you stop _____

If you roll your own cigarettes, how many ounces per week do you consume _____
If you do smoke do you want to stop smoking? Yes/No
Would you like to see our Support to Stop Smoking Nurse? Yes/No

Please estimate your weekly **alcohol** consumption …….. Units
(1 Unit = ½ Pint of Beer, or 1 Glass of Wine, or 1 Measure of Spirits)
Exercise: How much exercise do you take in a week? A – Enjoys light exercise, B – Enjoys moderate exercise, C – Avoids even trivial exercise, D – Enjoys heavy exercise or E – Enjoys intermediate exercise (please circle)

Please list any **current medical problems**

Past Medical History

Please give details of any serious illnesses, operations or admissions to hospital. Please include any important medical condition for which you have received treatment

Allergies to or severe side effects with Drugs and Tablets

Please tick A, B or C below depending on whether you are allergic to or develop reactions to drugs or tablets and if so which drugs.

A I am not allergic to any drugs [ ]

B **I am allergic to the following drugs** [ ]:

Drug or tablet	Description of side effects	Date noticed

C. I am allergic to some tablets but I cannot remember their name.[ ]

Personal Data

height…… weight……..

Family history

Please list any serious illnesses that have occurred in your **immediate family** (i.e. Father/Mother/Brother/Sister), such as heart disease, stroke, high blood pressure, diabetes, asthma, and cancer. **NOTE: THIS ONLY APPLIES TO RELATIVES WHO WERE UNDER 70 YEARS OF AGE WHEN THE DISEASE STARTED.**

Relation	Disease	Approximate age at onset

Are you a Carer? YES/NO Who do you care for? **……**

Do you have a carer? YES/NO Who cares for you? **……**

APPLICATION FORM FOR ONLINE PATIENT ACCESS

THIS SERVICE ALLOWS YOU TO BOOK APPOINTMENTS AND
ORDER REPEAT PRESCRIPTIONS ONLINE

Patient Surname……..…
First Name(s)……

Address……
……
…….……Post Code…….
Date of Birth……../……../……

Home Telephone Number……..Mobile……..

Email address……..

If you would like your prescription request to be proceeded through the electronic prescription system please inform us of your nominated pharmacy.	Pharmacy Name	

I apply to Nightingale Valley Practice to join the online Patient Access application service which gives me the ability to apply for GP appointments, order online prescriptions and basic medical information.

Terms and Conditions by Nightingale Valley Practice:
While we will make all reasonable efforts to provide the Service, we will not be liable for any failure to provide the Service, in part or full, for any cause that is beyond our reasonable control. This includes, in particular, any suspension of the Service resulting from maintenance and upgrades to our systems or those of any party used to provide the Service.
You must keep your Personal Details secret. You must take all reasonable precautions to prevent the fraudulent use of your Personal Details.
We reserve the right to change the Service from time to time and shall give you notice of any material changes. We may, where we consider it appropriate for you or your protection, suspend, withdraw or restrict the use of the Service or any part of the Service. We will tell you as soon as practicable if we take such action. We may also end the Service or any part of the Service at any time by giving you reasonable notice. We reserve the right to vary these Terms and Conditions and will give you 7 days' notice of any material changes. You may terminate this agreement by notifying us. The notification will not be effective until we receive it. While we will make reasonable efforts to provide the Service, we will not be liable for any failure to provide the Service, in part or full, for any cause that is beyond our reasonable control. This includes, in particular, any suspension of the Service resulting from maintenance and upgrades to our systems or those of any party used to provide the Service.

I accept the terms and conditions of Nightingale Valley Practice's service level agreement in this respect. I undertake to keep my User Name and PIN (Personal Identity Number) confidential and not to disclose this to any other person. I accept the limitation of booking a maximum of two GP appointments in any one 24 hour period. I undertake to give at least 24 hours' notice of cancelling any appointment booked (either via the internet or by other conventional means – e.g. telephone, in person at reception or in writing). Failure to do so may mean the withdrawal of this facility to me by Nightingale Valley Practice.

Signed……..…… Dated……..