UEA MEDICAL CENTRE - NEW PATIENT HEALTH STATUS QUESTIONNAIRE

Office use only	VERSION V7
EMIS No.	
Reg clerk	
Reg date	
Eligibility	
*Appt	

Please answer the following questions as accurately and completely as you can, as they will form a part of your medical record.
All information will remain confidential – This form has two sides

Last Name: _____ Forename: _____

DOB DD/MM/YY _____

Next of Kin ***Who you would like us to contact in the event of an emergency***
Name & contact number(s):

[ ] Male [ ] Female

UEA School: _____ Year of study: *(tick)* [ ] UG 1st [ ] UG 2nd [ ] UG 3rd [ ] UG other [ ] PG 1st [ ] PG other [ ] Non-student

Course end date *(year):* _____

***UK** Mobile number: _____ Email address: _____

[ ] **Tick if you wish to **opt IN** of text message reminders*
[ ] **Tick if you wish to **opt OUT** of text message reminders*

*NB/ **We are unable to accept qq.com emails** – please give alternative email*
We may use your email address for medical correspondence

Nationality: _____ Main spoken language: _____

Ethnicity *(please tick one box)*

White	Mixed	Asian or Asian British	Black or Black British	Other Ethnic Groups
[ ] British	[ ] White & Black Caribbean	[ ] Indian	[ ] Caribbean	[ ] Chinese
[ ] Irish	[ ] White & Black African	[ ] Pakistani	[ ] African	[ ] Other ethnic group
[ ] Other White background	[ ] White & Asian	[ ] Bangladeshi	[ ] Other Black background	[ ] Prefer not to say
	[ ] Other mixed background	[ ] Other Asian background		

! IMMUNISATIONS – ESSENTIAL INFORMATION REQUIRED *YOU MUST COMPLETE THIS SECTION*

You are strongly advised by the UEA, INTO & UEA Medical Centre to ensure you are fully immunised to UK Department of Health standards. There is an increased risk of Meningitis, Measles, Mumps and Rubella due to the large numbers of students in the close confines of a university campus, therefore it is important that you are vaccinated to protect both yourself and others.
Please indicate if you have/have not had the following;

Meningitis ACWY vaccine	[ ] Yes, date (MMYY) ……	**OR** [ ] Yes, had but unsure of date	**OR** [ ] *No, not had
1st MMR (measles, mumps, rubella) vaccine	[ ] Yes, date (MMYY) ……	**OR** [ ] Yes, had but unsure of date	**OR** [ ] *No, not had
2nd MMR (measles, mumps, rubella) vaccine	[ ] Yes, date (MMYY) ……	**OR** [ ] Yes, had but unsure of date	**OR** [ ] *No, not had
1st Covid vaccine	[ ] Yes, date (MMYY) …… Brand ……	**OR** [ ] *Not had, I would like one	**OR** [ ] No, not had and do not want
2nd Covid vaccine	[ ] Yes, date (MMYY) …… Brand ……	**OR** [ ] *I need my 2nd dose	**OR** [ ] No, not had and do not want

Q1 Have you lived in a country other than the UK for 6+ months in the last year **or** were you born in another country?
[ ] No [ ] Yes; if *yes, where?* *(please write below)*

……

Q2 Have you been diagnosed with any of the following conditions? [ ] No - *none* [ ] Yes - *Please tick those that apply;*

[ ] Cancer *(current)*
[ ] Diabetes
[ ] Eating disorder
[ ] Epilepsy
[ ] Mental Illness requiring treatment
[ ] On repeat medication requiring very regular blood tests
[ ] On treatment for gender transitioning

[ ] *Chronic Kidney Disease (CKD)
[ ] *Diabetes
[ ] *Pre-Diabetes
[ ] *Heart Disease
[ ] *Hypertension *(Raised Blood Pressure)*
[ ] *Stroke
[ ] Asthma *…please also tick the following - if they apply;*
  [ ] *and used an inhaler within the last 12 months
  [ ] *and use an inhaler 3+ times per week

Q3 Do you take any prescribed medication at present? [ ] No [ ] Yes; *if yes, what (Please include the pill and depo-injection)*

……

Q4 Do you have any allergies? [ ] No [ ] Yes*; if yes, what* ……

……

Q5 What is your: **Height**? …… *(cm/ft inches)* **Weight**?……..*(kilo/stone)* **BMI**?……*(if known)*

Q6 Have you **any disability/communication needs**? [ ] No [ ] Yes*; if yes, what* ……

……

Q7 Are you are Carer? *(Do you care for someone with specific needs)* [ ] No [ ] Yes*; if yes, who for?*……

Q8 FEMALES ONLY - please answer this boxed section if applicable

a) Do you require contraception? [ ] No [ ] Yes

b) Have you ever been sexually active? [ ] No [ ] Yes; *if yes, please answer questions c, d &e. If no, go straight to Q11.*

c) When was your last cervical smear/PAP? (date/year)……

d) Have you ever had an abnormal smear/PAP? [ ] No [ ] Yes*; if yes, what was the date/year?* ……

e) Number of pregnancies ……

Q9 Do you **smoke**? [ ] Never [ ] Used to (not now) [ ] Current smoker – *how many per day?* ……

Q10 Do you **drink alcohol**? [ ] No [ ] Yes*; if yes, please proceed to the questions below and circle your answer:*

QUESTIONS	SCORING SYSTEM				
	0	1	2	3	4
How often do you have 8 (men) / 6 (women) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
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
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Daily or almost daily

*****PLEASE READ THIS SECTION CAREFULLY******

Confidentiality & data protection statement: *The practice treats the information you provide as confidential. Further information about how your data is used is available to view on our website. www.umsuea.co.uk . Please note that email correspondence is not encrypted.*

1. UEA student records - We only access this system if we need to verify details.	[ ] *Tick to opt IN* [ ] *Tick to opt OUT*
2. Automatic Data Extractions - The UK Government wishes to use your data for health and research purposes. Your anonymised data will be automatically extracted unless you choose to opt out. Please tick the following box if you wish to opt out from sharing your medical record with private, third party organisations. If you tick opt out, we will updated your data extraction wishes.	[ ] *Tick to opt OUT*
3. Summary Care Record (SCR) - Your Summary Care Record is a short summary of your GP medical records. It tells other health and care staff who care for you about the medicines you take and your allergies. To help the NHS to respond to the coronavirus (COVID-19) pandemic, additional Information will be included in Summary Care Records for patients by default, unless you have previously told the NHS that you did not want this information to be shared. **Select either A, B or C**	[ ] A) Yes, I would like an SCR and express consent for medication, allergies and adverse reactions only or; [ ] B) Yes, I would like an SCR and express consent for medication, allergies, adverse reactions and additional information or; [ ] C) NO – I would not like an SCR and express my dissent (opt out)

Any other relevant information – please use a separate piece of paper, ensuring your name & date of birth are clearly stated

Office use only	VERSION V7
EMIS No.	
Reg clerk	
Reg date	

COMPLETION OF THIS QUESTIONNAIRE DOES NOT REGISTER YOU WITH A DOCTOR

We need to receive your signed GMS1 (GP registration) form in order for you to be registered

Office use only: [ ] HC not required [ ] *AR booked [ ] AR refused [ ] *TB screen only [ ] *Imms required
[ ] Practice leaflet given at reg [ ] Dr appt needed [ ] Smoking Cessation