NEW PATIENT QUESTIONNAIRE

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| NAME |  | | DOB |  | |
| ADDRESS  POSTCODE |  | | TELEPHONE NUMBER |  | |
| MOBILE NUMBER |  | |
| Would you be happy to receive appointment reminders from us via SMS text message  YES NO | | |
| MARITAL STATUS |  | | EMAIL ADDRESS |  | |
| NEXT OF KIN | Name  Relationship | | Address | Tel No | |
| ETHNIC ORIGIN | Please indicate below | | MAIN SPOKEN LANGUAGE Please state |  | |
| WHITE | British | | European | Other White | |
| MIXED | White/Black Caribbean | | White/Asian | White/Black | Other |
| BLACK/BLACK BRITISH | Caribbean | | African | Other | |
| ASIAN/ASIAN BRITISH | Indian | Pakistani | Bangladeshi | Other | |
| OTHER ETHNIC | Chinese |  | Other Ethnic Backgrounds |  | |

|  |  |
| --- | --- |
| **Are you a Carer?** (Do you provide support to a friend/relative because of disability illness or effects of old age.) |  |
| **Does someone care for you?** (Provide support to you because of disability, illness or frailty) |  |
| DO YOU HAVE A **DISABILITY**?  Do you have any access needs/hearing difficulty |  |

|  |  |  |
| --- | --- | --- |
| **NHS SUMMARY CARE RECORD** | | |
| Have you previously consented to information sharing? | YES | NO |
| Do you wish to consent or decline to information sharing? *Please circle* | **CONSENT** | **DECLINE** |
| Please ensure you have read the information regarding this and complete an **Opt Out** form from Reception if you wish to **decline.** | | |

|  |
| --- |
| **DATA SHARING**  This is not the same as the NHS Summary Care Record. Please read “Your Data Matters” and follow the instructions regarding data opt-out if you do not wish your information to be shared in this way.  You can complete an Opt Out form from Reception if you wish to prevent sharing of your personal confidential information held by the practice other than for individual care. |

|  |  |
| --- | --- |
| **ALLERGIES** | |
| Are you allergic to any medication? – which? |  |
| Any other allergies? eg Elastoplast |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **DO YOU SMOKE**? YES NO (please circle) | | IF YES, HOW MANY PER DAY? |  |
| If you smoked in the past, how many per day?  When did you stop |  | For advice on stopping smoking, please contact the Smoking Cessation Clinic. 01670 813135 | |
|  |

|  |  |
| --- | --- |
| **DIET**  Do you follow any special diet? – please specify |  |
| **EXERCISE**  How many days a week to you exercise?  What kind of exercise do you do? |  |

|  |  |
| --- | --- |
| **WOMEN ONLY** | |
| Cervical smear – Please give date of last smear  Have you had any previous abnormal results? |  |
| Have you had breast screening?  If yes, when? |  |

|  |  |
| --- | --- |
| **MEDICAL HISTORY – MEN AND WOMEN** | |
| PLEASE LIST BELOW ANY MAJOR ILLNESS, DISABILIITIES OR OPERATIONS | |
|  |  |
|  |  |
|  |  |
|  |  |

|  |  |
| --- | --- |
| **MEDICATION** |  |
| ARE YOU CURRENTLY TAKING ANY MEDICATION OR TREATMENT (including over the counter medicines)? PLEASE LIST BELOW | |
|  |  |
|  |  |
|  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **FAMILY HISTORY** Do you have a close family history of any of the following? | | | |
| CONDITION | | *FAMILY MEMBER* | *AGE* |
| HEART DISEASE *Please state family member and age* | |  |  |
| STROKE *Please state family member and age* | |  |  |
| DIABETES | |  | |
| ASTHMA | |  | |
| CANCER | BOWEL |  | |
|  | BREAST |  | |
|  | OVARIAN |  | |
|  | LUNG |  | |

**NEW PATIENT QUESTIONNAIRE ALCOHOL FAST SCORING KEY**

*PATIENTS AGED 16 AND OVER*

HOW MANY UNITS OF ALCOHOL DO YOU DRINK PER WEEK?

1 UNIT = 1 MEASURE OF SPIRIT

1 GLASS OF WINE OR SHERRY

HALF A PINT OF BEER OR LAGER

For the following questions please circle the answer which best applies.

1)

MEN How often do you have EIGHT or more drinks on one occasion?

WOMEN How often do you have SIX or more drinks on one occasion?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 |
| Never | Less than monthly | Monthly | Weekly | Weekly or almost daily |

2)

How often during the last year have you been unable to remember what happened the night before

because you had been drinking?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 |
| Never | Less than monthly | Monthly | Weekly | Weekly or almost daily |

3)

How often during the last year have you failed to do what was normally expected of you because

of drinking?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 |
| Never | Less than monthly | Monthly | Weekly | Weekly or almost daily |

4)

In the last year has a relative or friend, doctor or other health worker been concerned about your

drinking or suggested you cut down?

|  |  |  |
| --- | --- | --- |
| 0 | 2 | 4 |
| No | Yes, on one occasion | Yes on more than one occasion |

***THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE***