New Patient Questionnaire

Your details

Forename(s):		Surname:	
Date of Birth:		Sex:	
Home Telephone Number:		Mobile Telephone Number:	
Occupation:		Email Address:	
Marital Status		Ethnicity:	
Main Language:		Interpreter Required?	

Next of kin details

Next of Kin		Relationship:	
Contact Number:			

Have you been registered with our practice before? YES ☐ NO ☐

SMS Text Messaging Service

The practice provides a text messaging service for our patients. This can include contacting you for health campaigns, test results and appointment reminders via text message. If you would to utilise this service please tick below. Your details are not shared outside of the practice.

☐ I agree for text messages to be sent to the mobile number provided.

Pharmacy Choice

The practice is able to send prescriptions electronically to a pharmacy of your choice. This means that you no longer need to collect your prescription from the practice and take it to the pharmacy and wait. Please select which pharmacy you use and where you would like your prescriptions to go.

Please tick your chosen local chemist;

Boots (Cortonwood)		Well (Darfield)	
McGills (Wath)		Knollbeck (Brampton)	
Morrisons (Cortonwood)		Rowlands (Wath)	
Tesco (Wath)		Weldricks (Swinton)	

Do you have any of the following medical conditions that we should know about? If so, please tick the box below;

- ☐ Chronic Heart Disease
- ☐ Stroke
- ☐ Mini-stroke
- ☐ High blood pressure (Hypertension)
- ☐ Diabetes (Type 1)
- ☐ Diabetes (Type 2)
- ☐ Chronic Obstructive Pulmonary Disease
- ☐ Asthma
- ☐ Epilepsy
- ☐ Depression
- ☐ Anxiety
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Other:______________________________

Medical Information

If you are taking regular medication please attach printed list of medication from your current GP. If you do not have a copy of this please request this from the GP you are currently registered with, we can then add you medication onto you medical records at our practice.

Do you have any allergies or sensitivities to any medications? If so, please write them below;

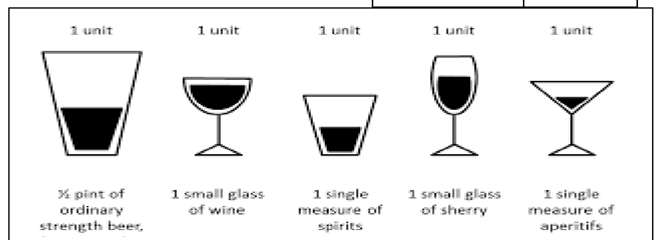
Smoking Information

Are you a smoker?		Have you smoked before?	
If so, what do you smoke (inc e-cig)?		When did you stop smoking?	
And, how much do you smoke?			

Alcohol consumption details

Questions	0	1	2	3	4	Your Score
How often do you have an alcoholic drink?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking alcohol?	1 - 2	3 – 4	5 – 6	7 – 8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you had started?	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	
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	
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	
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	
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	
Has a relative, friend, doctor or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
SCORING:					TOTAL	

0 - 7 Sensible drinking 8 - 15 Hazardous drinking
16 - 19 Harmful drinking 20+ Possible dependence



SIGNATURE...

DATE...

For Office Use: **Date Forms received: / /** **Received by …………**

Proof Of ID Provided? YES ☐ **NO** ☐ **Proof of Address? YES** ☐ **NO** ☐