**NEW PATIENT QUESTIONNAIRE**

**Please nominate a local Pharmacy that you would like your prescriptions to go to**

Asda [ ]  Boots High Street [ ]  Boots St Peters Hill [ ]  Superdrug [ ]  Lloyds High street [ ]  Lloyds Alma Park [ ]

Co-op Winchester Rd [ ]  Co-op Hornsby Rd [ ]  St Peter’s Hill [ ]  None [ ]

Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Forename \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex \_\_\_\_\_ Marital Status \_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Consent to SMS Yes [ ]  No [ ]

Country of Origin \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **1st Language \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ English Speaker \_\_\_\_\_\_**

Ethnicity:

White British [ ]  British or Mixed British [ ]  Irish [ ]

Other White [ ]  White & Black Caribbean [ ]  White & Black African [ ]

White & Asian [ ]  Other mixed background [ ]  Indian & British Indian [ ]

Other Asian background [ ]  Pakistani or British Pakistani [ ]  Caribbean [ ]

Other Black background [ ]  Bangladeshi or British Bangladeshi [ ]  African [ ]

Other Ethnic Category [ ]  Ethnic Category not stated [ ]  Chinese [ ]

Next of Kin (Name, Telephone No and relationship) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_FOR CHILDREN ONLY**

Please give details of those who have parental responsibility for this child :

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Should you wish to authorise any person other than those who have parental responsibility to bring the child to appointments/ speak to a GP on your behalf please give their details below:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact number:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CARERS**

Do you need / have anyone who looks after you or your daily needs as a Carer? Yes [ ]  No [ ]

If “Yes”, would you like them to deal with your health affairs here? Yes [ ]  No [ ]

 (T**he receptionist can help with these arrangements**)

Do you care for anyone else? Yes [ ]  No [ ]

If “Yes” please print patients name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COMMUNICATION**

Should you have any specific communication needs ie large print, interpreter, please specify here :

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH**

Smoker: Yes [ ]  No [ ]  No/day \_\_\_\_\_\_\_ Smoking Advice: Yes/No

Past Smoker: Yes [ ]  No [ ]  No/day \_\_\_\_\_\_\_ Quit (year) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever smoked Yes [ ]  No [ ]

Alcohol per week Pints of Beer \_\_\_\_\_\_\_\_\_ Glasses of Wine \_\_\_\_\_\_\_\_\_ Spirits \_\_\_\_\_\_\_\_\_\_\_

1) 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 [ ]

2) 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+ [ ]

3) How often do you have 6 or more standard drinks on one occasion?

Never [ ]  Less than monthly [ ]  Monthly [ ]  weekly [ ]  daily or almost daily [ ]

Exercise: Do you enjoy or Avoid \_\_\_\_\_\_\_\_ If so Light/Moderate/Heavy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diet: Normal [ ]  Vegetarian [ ]  Vegan [ ]

Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

Allergies: (to medicine, animals etc)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Members History (Mother, Grandfather etc)**

Angina \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_ Heart Attack \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_

Other Heart Problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Stroke \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Asthma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hypertension \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Height \_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_**

Please give details of any past serious illnesses/fractures/operations/births etc. on the back page

![Description: St[1]]()

![Description: St[1]]()

**Record sharing**

Do you consent to the sharing of data recorded here at St Peter’s Hill Surgery with any other organisations that may care for you?

**Sharing Out**

[ ]  Yes – share data with other organisations

[ ]  No – Do not share any data recorded here

**Sharing In**

Do you consent to the viewing of data by this organisation that is recorded at other care services that may care for you where you have agreed to make the data shareable?

[ ]  Consent given

[ ]  Consent refused

Name ………………………………………. Date of Birth …………………..

Signed ………………………………………. Date……………………………..

**PLEASE tick both sections**

**Record sharing**

Do you consent to the sharing of data recorded here at St Peter’s Hill Surgery with any other organisations that may care for you?

**Sharing Out**